THE DENTAL
ANESTHESIA CENTER

**Patient Name**: _____ **Date:** _____

Expires in 1 year

## Acknowledgement — Receipt of Notice of Privacy Practices (HIPAA)

We are required by law to provide you with a copy of our Notice of Privacy Practices, which explains your rights and our legal duties concerning your protected health information and how we may use and disclose your protected health information.

**Name of Person(s) The Dental Anesthesia Center can disclose your protected Health and Dental information with:**

_____

_____

_____

## Other Methods of Communication

You may ask us to communicate with you by other methods. I request to receive/release communication of my protected health information by any of the methods described below.

U.S. Mail / Home, Work, Cell Phone /Answering Machine/ E-mail/ Text Message

## Acknowledgement by Patient/Personal Representative(s)

If you are the Patient or a Personal Representative acting on the behalf of the patient, please check the appropriate box below and sign at the bottom of the form. Proof of your authority to act may be requested.

I received the Notice of Privacy Practices of The Dental Anesthesia Center.

❑ Self ❑ Guardian ❑ Parent ❑ Support Staff: (Name/Title: _____)

X_____

**Signature** **Printed Name**