THIS IS OUR HIIPA PRIVACY POLICY. THE POLICY STATES WE WILL NOT GIVE OUT ANY OF YOUR HEALTH INFORMATION WITHOUT WRITTEN CONSENT FROM YOU, THE PATIENT. FOR MINORS, PLEASE WRITE YOUR MINOR'S NAME AND SIGN AS THE PARENT OR GUARDIAN OF PATIENT. IF YOU WOULD LIKE A COPY OF THIS POLICY IN FULL, PLEASE ASK FOR ONE. THANK YOU!!

Old Capital Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a
(Print name of patient)

Copy of this office's Notice of Privacy Practices.

_____
(Please print name of patient)

_____
(Signature of responsible party)

_____
(Date)

_____
For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- **Individual refused to sign**
- **Communications barriers prohibited obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other (please specify)**

_____
_____
_____