William H. Miller, DMD, PA

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for William H. Miller, DMD, PA this ___ day of _____, 20__. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____
Please print your name

_____
Please sign your name

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority _____.

Thank you and if you have any questions about this form or the attached Notice, please contact our Privacy Official.

Office Use Only

As Privacy Official, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign
because (please describe) ____

_____
Signature of privacy official