James D. Prigmore D.D.S., Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, ________________________, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name) ______________________________ **(Date)** __________________

(Signature) ______________________________

Permission to Share Health Information

May we call and leave a message or test results on your answering machine if you are not home?

_______Yes _______No

May we leave a message or test results with someone other than yourself if you are not home?

_______Yes _______No

With whom are we allowed to leave a message?

Name (print) ______________________________ **Relationship (print)** ______________________________

May we share your personal health information with someone in your family or a friend who calls about you? _______Yes _______No

With whom are we allowed to speak?

Name (print) ______________________________ **Relationship (print)** ______________________________

Signed ______________________________ **Print Name** ______________________________

______Parent of guardian or minor patient **______Parent or conservator of "special needs" patient**