Michael B. Hill, D.D.S., P.C.
1951 West 4700 South, #4
Taylorsville, UT 84118
(801) 966-8921

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this Acknowledgement **

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My signature below confirms that I have received a copy of this office's Notice of Privacy Practices which details how my protected health information may be used or disclosed.

I understand that I may request in writing that this office restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that this office is not required to agree to my requested restrictions, but that if you do agree, then you are bound to abide by such restrictions.

Patient name (printed): _____ Date_____

Signature: _____

Relationship to patient: _____

Dependent family members (under age 18) also covered by this acknowledgement:

_____

_____

_____

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FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ Emergency situation prevented us from obtaining the acknowledgement
- □ Other (please specify) _____