



San Antonio Oral & Maxillofacial Surgery Associates, P.A.  
www.saomsa.com

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*You May Refuse to Sign This Acknowledgment\*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices. I give authorization for the doctor or staff to discuss information concerning my

- Health History \_\_\_\_\_ (initial)
- Financial Issues \_\_\_\_\_ (initial)
- Treatment Planning \_\_\_\_\_ (initial)

with (name of person/persons) \_\_\_\_\_.

I do not give permission to release or discuss my records to anyone outside the state or federal mandates. \_\_\_\_\_

A copy of the Power of Attorney has been provided. Yes / No

Print Patient or Representative Name \_\_\_\_\_

Patient or Representative Signature \_\_\_\_\_

Date \_\_\_\_\_

### For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify) \_\_\_\_\_

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