

Regional Oral Surgery Center

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies (Minor)

I have received a copy of the Notice of Privacy Practices of Regional Oral Surgery Center. I hereby authorize, as indicated by my signature below, Regional Oral Surgery Center to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Print Name (Patient) _____

Address _____

Signature (Parent) _____

Date _____

Please check your preferred means of communication:

- You may contact me at my home telephone number _____
- You may contact me on my mobile telephone number _____
- You may contact me on my work telephone number _____
- You may send me an email at: _____
- Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed: _____
2. _____ Date Added / Removed: _____
3. _____ Date Added / Removed: _____
4. _____ Date Added / Removed: _____

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify) _____

Staff Person Initials _____