where smiles grow up

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDEMENT OF RECEPT

______________________________ (Patient Name / Your Child's First & Last Name)   ______________________________ (Today's Date)

____ (First & Last Name of ALL Siblings)

We will try and contact you through call or text.

Parent/Guardian: ______________________________   Phone: _____-_____-__________

Patient Authorization for Use and Disclosure of Protected Health Information
I authorize Emhardt Pediatric Dentistry, their Health Care Providers, and other personnel permission to discuss, health and insurance information, in person or by telephone with the following family members or friend involved in my child/children's dental care. Please list additional family/friends, and state the person's relationship to the patient, and phone number to contact them if needed.

1. ______________________________ Name (Please Print) (Relationship to Patient)   ____________________ (Contact Number)
2. ______________________________ Name (Please Print) (Relationship to Patient)   ____________________ (Contact Number)
3. ______________________________ Name (Please Print) (Relationship to Patient)   ____________________ (Contact Number)

I, ______________________________, have been offered a copy of this office's Notice of Privacy Practices.
(Parent/Guardian Name)

______________________________ (Please Print Parent/Guardian Name)   ______________________________ (Parent/ Guardian Signature)

FOR OFFICE USE ONLY
Emhardt Pediatric Dentistry made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices.* In spite of these efforts, Emhardt Pediatric Dentistry was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on __________, 20____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):______________________________

Date Received	By	Patient ID

John R. Emhardt DDS MSD
1818 North Riley Highway, Suite B | Shelbyville, IN 46176
317-699-6109 office | 317-825-0063 fax | emhardtpediatricdentistry.com