Bellevue Dental Care, P.C.

PRIVACY PRATICES ACKNOWLEDGEMENT

I have received/reviewed the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name _____ (please print)

Patient Signature _____

I give my permission to Bellevue Dental Care to release information regarding my case or account to Name_____

_____

Dated _____

<<<<<<<<<<<<<<<<<To be completed by office>>>>>>>>>>>>>>>>>>>

Written acknowledgement could not be documented due to:

_____ Patient refused to sign

_____ Personal representative not available to sign

_____ Language, communication, or effects of disability impeded acknowledgement

_____ Emergency care impeded acknowledgement

_____ Other, please specify _____