

HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of the Nova Southeastern University Dental Clinics HIPAA Notice of Privacy Practices.

Patient Name (Print)

Patient Signature

If completed by a patient's personal representative, please print, and sign your name in the space below.

Personal Representative Name (Print)

Personal Representative Signature

Relationship

Date

FOR OFFICE USE ONLY

I have made a good faith effort to obtain a written acknowledgement of receipt of the NSU Notice of Privacy Practices. However, an acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because: _____
- Due to an emergency situation, it was not possible to obtain an acknowledgment.
- Other: _____

Employee Signature

Date

Date: April 2003

Revision: May 2014

File in Patient Chart