

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RULES

I, _____, have received and/or reviewed a copy of the
(*Patient's Name*)
Notice of the Privacy Practices for the office of **Sherman Oaks Dental &
Dental Sleep Medicine of Illinois.**

Please sign and date: _____ Date: _____
(parent signature if a minor)

OPTING OUT:

- I **do not** want appointment reminder messages left on my home answering system; I understand that the office may charge me should I fail to keep my appointment.
 - I **do not** want appointment reminder messages left at my place of employment; I understand that the office may charge me should I fail to keep my appointment.
 - I **do not** want appointment reminders by e-mail.
 - I **do not** wish my protected health care information to be released to the following persons _____ .
(*give name and address*)
 - I **decline** to sign the Acknowledgement.
-

OFFICE USE:

The office was unable to obtain a signed Acknowledgement form from the above patient for the following reasons: