

**Brown and Neuwirth
Oral & Cosmetic Surgery Center**

Acknowledgment of Receipt of Notice of Privacy Practices

* You may refuse to sign this Acknowledgment

I, _____, have been afforded the opportunity to read this office's Notice of Privacy Practices.

Please Print Name

Relation to Patient (self, parent, or legal guardian)

Signature

Date

PATIENT AUTHORIZATION

In order for our practice to comply with HIPAA Federal Regulations, we ask that you read and sign this, so that we may provide you with the best care and treatment, while safeguarding your privacy.

If you have family and or a friend that will be calling requesting information, this **MUST** be signed by you, or no information regarding your care will be given to anyone other than yourself.

I authorize Drs. Brown & Neuwirth to release my medical information to my personal patient representative(s).

Name of personal representative: _____

Date: _____ Relationship: _____

Contact #: _____ Contact #: _____

Name of personal representative: _____

Date: _____ Relationship: _____

Contact #: _____ Contact #: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices,
but acknowledgment could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining the acknowledgment

___ An emergency situation prevented us from obtaining acknowledgment

___ Other (please specify)

