The office of:
Jennifer J. Jerome D.D.S., INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received and had the opportunity to read this office's Notice of Privacy Practices.

Please print name

Signature

Date

Completion is voluntary, but required if disclosure is requested or if an insurance claim is submitted from this office.

____ This information may be disclosed to and used by the following person or organization:

Name	Relationship
Name	Relationship
Name	Relationship

____ I authorize that my records may be released to any family member that calls.

Patient or Guardian Signature Date

_____

For Office Use Only

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

_____ Individual refused to sign

_____ Communications barriers prohibit obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please Specify)

_____