DENTAL HEALTH ASSOCIATES OF MADISON, LTD.
RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____
Dental Record #: _____
Date of Visit: _____

My signature on this form acknowledges that I have received a copy of **Dental Health Associates of Madison, Ltd. ("DHA")** Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by **DHA** and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

_____ _____
Patient's Signature Date

_____ _____
Signature of Patient's Representative Date
if patient is unable to sign

TO BE COMPLETED BY DENTAL OFFICE IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of the Notice of Privacy Practices?
☐ **Yes** ☐ **No**

2. Briefly describe the efforts made to obtain the patient's acknowledgement of receipt of the Notice and explain why the patient was not able or unwilling to sign this form: _____
_____
_____
_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE