Dream Dentistry & Sleep Care™
EXPERIENCE THE EXCEPTIONAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, (print/type name) _____, have received and read a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

Dream Dentistry may release information to the following people (print/type name):

_____ _____

_____ _____

Your visit to our office may be recorded in audio and video for security, educational, or quality control purposes. If you object to this, please advise any staff member. Thank you.

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 prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

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