

BUCHANAN FAMILY DENTISTRY

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I may refuse to sign this acknowledgement.

I have been offered and / or received a copy of Buchanan Family Dentistry's Notice of Privacy Practices.

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party. I understand that I may request a copy of the privacy policies at any time.

Please Print Name

Signature

Date

Expiration -- 3 Years from Initial Signature: _____
Date

Expiration -- Change In Insurance Coverage