CHESTER FAMILY DENTAL CARE, LLC
726 Wilson Street
Chester, South Carolina 29706
803-581-2345

ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, ____, {Please Print Name} have read a copy of this office's Notice of Privacy Practices.

____{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 prevented us from obtaining acknowledgement
_____Other (Please Specify) ____

PERMISION TO ACCESS DENTAL RECORDS

I, ____(PATIENT NAME) give permission to the following people to access my dental records-

____(PATIENT, PARENT OR GUARDIAN SIGNATURE)

____(DATE)

1. ____ Name

____ Relationship

____ Telephone Number

2. ____ Name

____ Relationship

____ Telephone Number

3. ____ Name

____ Relationship

____ Telephone Number