



HIPAA Notice of Privacy Practices Acknowledgement of Receipt

Morrison Dental Group will use and disclose your personal health information to treat you, to receive payment for care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regard to protected health information. The terms of this notice may change with time, and we will post the current notice at our facility and have copies available for distribution.

The financially responsible party, if it is not me, has the right to discuss my account balance. I also give **Morrison Dental Group** permission to speak to the following people (if any) regarding my health information:

I hereby acknowledge that I have and read a received a copy of Morrison Dental Groups HIPAA Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary of personal representative of deceased patient

Name of Patient: _____

FOR OFFICE USE ONLY:

Signed form received by: _____

Acknowledgement refused: _____

Reason for refusal: _____

6/10/24

