HIPAA RECEIPT

ARIVE a FAMILY DENTAL

CRAIG ARIVE D.D.S.

OWN YOUR SMILE

PLEASE PRINT

RECEIPT OF NOTICE OF PRIVACY PRACTICES - WRITTEN ACKNOWLEDGMENT FORM

I acknowledge that I have received a copy of Arive Family Dental's Notice of Privacy Practices explaining, but not limited to, the following:

- How the office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- The office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request. I also understand that if I have any questions or complaints, I may contact:

Craig Arive, DDS

4019 Columbus Ave, Suite D

Indianapolis, IN 46013

Patient Name: *Parent, Guardian, or Personal Representative Name (state relationship):*

Patient, Parent, Guardian, or Personal Representative Signature: *Date:*

AUTHORIZATION TO DISCUSS YOUR INFORMATION WITH FAMILY, FRIENDS OR CAREGIVERS

I authorize Arive Family Dental to discuss and/or release my protected health information including diagnoses, lab and test results, and treatments discussed to the following persons:

Name: *Relation:* *Date:*

Name: *Relation:* *Date:*

Patient Signature: *Responsible Party Signature:*

FOR OFFICE USE ONLY

We attempted to obtain acknowledgment of receipt of our Notice of Privacy Practices but acknowledgment could not be obtained because:

- ❍ Individual refused to sign
- ❍ Communications barriers prohibited us from obtaining the acknowledgment
- ❍ An emergency situation prevented us from obtaining the acknowledgment
- ❍ Other

BRUSH YOUR SMILE +  FLOSS YOUR SMILE ⇨  OWN YOUR SMILE

THANK YOU!