William B. Chan & Associates

Privacy is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of William B. Chan, DMD, Inc. I hereby authorize, as indicated by my signature below, William B. Chan, DMD, Inc. to use and to disclose my child's protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ Print Child's Name

_____ Address

_____ Name of parent/legal guardian

_____ Name of parent/legal guardian

_____ Signature

_____ Date

Please check your preferred means of communication:

☐ Cell Phone (____) _____-_____ ☐ Home Phone (____) _____-_____

☐ Work Phone (____) _____-_____ E-mail:_____

☐ Other:_____

Please list authorized persons with whom we may discuss your child's Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1._____ Relationship:_____ Date ___/___/___ (circle) Added Removed

2._____ Relationship:_____ Date ___/___/___ (circle) Added Removed

3._____ Relationship:_____ Date ___/___/___ (circle) Added Removed

4._____ Relationship:_____ Date ___/___/___ (circle) Added Removed

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining the acknowledgement
☐ Other (Please specify)_____

Staff member initials: _____