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## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

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— You May Refuse to Sign This Acknowledgement —

I, \_\_\_\_\_, have received a copy of J. Rice Oral Maxillofacial and Aesthetic Facial Surgery, P.C.'s Notice of Privacy Practices.

Do you (the above mentioned) give the office staff of J. Rice Oral Maxillofacial and Aesthetic Facial Surgery, P.C. authorization to provide test results and/or patient information to a family member.

Yes  No  If yes, please provide family member's name etc. below...

Family Member's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Print Name \_\_\_\_\_

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 situation prevented us from obtaining acknowledgement
- Other (Please specify)

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