

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Thomas Homonnay, DDS. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Print Name

Signature

Address

_____/_____/_____
Date

City/State/Zip

Please check your preferred means of communication:

- You may contact me at my **home** telephone number: _ (_____) _____
- You may contact me at on my **mobile** telephone number: _ (_____) _____
- You may contact me at on my **work** telephone number: _ (_____) _____
- You may send me an **email** at: _____
- Other: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed: _____
2. _____ Date Added / Removed: _____
3. _____ Date Added / Removed: _____
4. _____ Date Added / Removed: _____
5. _____ Date Added / Removed: _____

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify): _____