Nolensville Pediatric Dentistry

Your Privacy is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies (Minor)

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

______________________________	______________________________
Parent or Legal Guardian	Address
______________________________	______________________________
Signature	Date

☐ **Please check your preferred means of communication:**

☐ **You may contact me at my home telephone number** ______________________

☐ **You may contact me at my mobile telephone number** ______________________

☐ **You may contact me on my work telephone number** ______________________

☐ **You may send me an e-mail at** ______________________________________

☐ **Other** ____

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

1. ________________________________Date Added/Removed:____________
2. ________________________________Date Added/Removed:____________
3. ________________________________Date Added/Removed:____________
4. ________________________________Date Added/Removed:____________
5. ________________________________Date Added/Removed:____________

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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) ____