**ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES**

***Roxana Shahnavaz DDS***

***1010 Cass Ste #D4***

***Monterey, CA 93940***

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| Acknowledgement | |  | | | |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby acknowledge that I have received and reviewed a copy of Roxana Shahnavaz DDS's *HIPAA Notice of Privacy Practices*.  I understand that Roxana Shahnavaz DDS's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Roxana Shahnavaz DDS's revised *HIPAA Notice of Privacy Practices* upon request.  I understand that, if I have questions about Roxana Shahnavaz DDS's *HIPAA Notice of Privacy Practices*, I may contact Dr Shahnavaz’office.  I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Roxana Shahnavaz DDS will not refuse treatment to me if I refuse to sign this Acknowledgement.  I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Roxana Shahnavaz DDS's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Dr Roxana Shahnavaz noted above, for assistance. | | | | | |
|  |  | |  |  |  |
|  | Patient Signature | |  | Date |  |
|  |  | |  |  |  |
|  | Signature of Personal Representative | |  | Print Name of Personal Representative |  |
|  |  | |  |  |  |
|  |  | |  | Relationship of Personal Representative to Patient |  |

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| **FOR OFFICE USE ONLY**  Roxana Shahnavaz DDS made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, **Roxana Shahnavaz DDS** was unable to obtain a signed Acknowledgement for the following reason(s): | | | |
|  | Refusal to sign Acknowledgement on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_. | | |
|  | Communications barriers prohibited us from obtaining a signed Acknowledgement. | | |
|  | An emergency situation prohibited us from obtaining a signed Acknowledgement. | | |
|  | Other (Describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
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| Date Received | | By | Patient ID |