Magnolia Pedraza, DMD MS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and HEALTHCARE INFORMATION DISCLOSURE

I have received a copy of this office's Notice of Privacy Practices and Healthcare Information Disclosure

_____

Name of Patient

_____

Patient Signature **Date**

This patient's health information may be shared with the following people:

Name_____Relationship to patient_____ Phone _____
Name_____Relationship to patient_____ Phone _____
Name_____Relationship to patient_____ Phone _____

If this Consent is signed by a personal representative on behalf of the patient

Personal Representative's Name_____
Relationship to Patient _____
Personal Representative's Signature_____

You May Refuse to Sign This Acknowledgement

You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. This revocation will not affect any action we took in reliance on the Consent document before we received your revocation and we may decline to treat you or to continue treating you if you revoke this Consent.

Revocation letters should be sent or delivered to:
Magnolia Pedraza DMD, MS, 241 W. Weaver Rd. Suite 220, Forsyth, IL 62535

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Healthcare Information Disclosure, but the acknowledgement could not be obtained because:

- □ *Individual refused to sign*
- □ *Communication barriers prohibited obtaining the acknowledgement*
- □ *An emergency situation prevented us from obtaining acknowledgement*
- □ *Other (Please Specify)*_____