ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

LAKESIDE DENTAL
FAMILY & COSMETIC DENTISTRY

Patient Name: _____ **Date of Birth**: _____

Lakeside Dental's **Notice of Privacy Practices** explains how we may use and disclose your protected health information, your rights regarding that information, and our responsibilities for protecting your privacy.

By signing below, I acknowledge that Lakeside Dental has provided me with, or made available to me, a copy of its Notice of Privacy Practices.

I understand that:

- I may request a paper copy of the Notice at any time, even if I received or reviewed it electronically.
- I may ask questions about the Notice or about how my health information is used or disclosed.
- Signing this acknowledgment confirms that I received or was given access to the Notice. It does not authorize uses or disclosures beyond those permitted or required by law.
- Lakeside Dental may revise its Notice of Privacy Practices. The current Notice will be available at the office and on the practice website.
- I may request restrictions on certain uses or disclosures of my health information, although Lakeside Dental may not be required to agree to every request.

The **HIPAA Privacy Rule** requires a dental practice with a direct treatment relationship to provide its Notice no later than the first service delivery and make a good-faith effort to obtain written acknowledgment. A patient's refusal to sign does not prevent the practice from using or disclosing health information as otherwise permitted by HIPAA.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have received, or have been given access to, Lakeside Dental's Notice of Privacy Practices.

Patient's Signature: _____ Date: _____

PERSONAL REPRESENTATIVE

Complete this section only when someone is signing for the patient.

Name of Personal Representative: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Healthcare Agent ☐ Other: _____

Authority to Act for Patient, if applicable:_____

Personal Representative's Signature: _____ Date: _____

PRIVACY CONTACT

Questions, concerns, requests for copies, or privacy complaints may be directed to:

Privacy Contact: Dr. Keith Egan
Lakeside Dental
1011 Catherine Street
Salt Lake City, Utah 84116
Telephone: (801) 596-3000
Website: www.mylakesidedental.com

FOR OFFICE USE ONLY

Lakeside Dental made a **good-faith effort** to provide the Notice of Privacy Practices and obtain written acknowledgment, but the acknowledgment was not obtained because:

☐ Patient declined to sign ☐ Patient was unable to sign ☐ Personal representative was unavailable
☐ Emergency treatment circumstances ☐ Communication or language barrier
☐ Notice was provided electronically, but acknowledgment was not returned ☐ Other: _____

Notice provided or made available by:

☐ Paper copy ☐ Electronic copy ☐ Practice website ☐ Other: _____

Staff Member: _____ Date: _____

Additional Notes:_____
_____
_____
_____