Receipt of HIPPA Notice of Privacy Practices

Please initial each blank indicating you have read and understood the statement.

____ I hereby acknowledge that I have received the HIPPA Notice of Privacy Practices from Putnam Family Dental which sets forth the way in which my personal health information may be used or disclosed by Putnam Family Dental, and outlines my rights with respect to such information.

____ I have indicated any individuals below who may access my personal health information *(including information about my appointment date and times)*.
☐ **None**

Name	Relation
Name	Relation
Name	Relation

If the patient is a ***minor***, please state below the individuals (excluding parents/guardians) who can bring the patients to the appointments and make medical decisions on their behalf
☐ **None**

Name	Relation
Name	Relation

____ I understand that Putnam Family Dental may contact me via different communication methods; including but not limited to phone, text, email and postcard.

____ I authorize Putnam Family Dental to leave a message on my phone at the number indicated on my patient account.

_____ _____
Patient or Guardian's Signature Date

_____
Printed Name of Patient /Guardian