

DR. WILLIAM S. DEMRAY

**NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT AND CONSENT**

In accordance with federal HIPAA rules, I acknowledge that I have received the Notice of Privacy Practices from the dental office of Dr. William S. Demray and consent to the Privacy Practices specified.

If the patient is a minor under the age of 18, a parent or legal guardian must sign on behalf of the child.

Please Print Patient's Name

Patient's E-mail Address

Patient's Signature

Date

Print Name of Patient's Representative (when applicable)

Relationship to Patient (example: parent, legal guardian, personal representative)

Patient's Representative's Signature

Date

Employee/Witness Signature

Date

Documentation of Failure to Obtain Signed Acknowledgement

The staff member of Dr. Demray presented this Notice of Privacy Practices Acknowledgement and Consent form to patient, _____ .
The patient refused to provide a signature as requested.

Signature of Employee

Date



HIPAA

Effective April 14, 2003