Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with a copy of the **Notice of Privacy Practices** for **Dr. Terry Lassiter, DDS**, including information regarding my rights under HIPAA and, if applicable, special confidentiality protections for Substance Use Disorder records under federal law (42 CFR Part 2).

I understand that this Notice describes how my protected health information may be used and disclosed and how I can access this information.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

If signed by a personal representative:

Representative Name: _____

Relationship to Patient: _____

This acknowledgment will be retained in the patient's record.

Patient refused to sign - Notice of Privacy Practices

Office Staff Name: _____

Office Staff Signature : _____

Date: _____