



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practice provided by Michael A. Goyette, D.D.S., Inc.

I, _____, authorize Michael A. Goyette, D.D.S., Inc. to discuss my health information with the following persons:

Spouse: _____

Children: _____

Parent: _____

Other: _____

Date: _____ Patient Signature: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

____ Individual refused to sign

____ Communication barrier prohibited obtaining the acknowledgment

____ An emergency situation prevented us from obtaining acknowledgment

____ Other (Please specify) _____