_____ (ofc) 954.651.1254 (cell) sharaf@sharafdds.com www.sharafdds.com

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Ahmed Sharaf, DDS's Notice of Privacy Practices effective 3/1/17.

Patient's Name (please print)_____

_____ _____
Signature of Patient Date Signed

****

I am a parent or legal guardian of _____ (patient's name). I have received a copy of Ahmed Sharaf, DDS' Notice of Privacy Practices effective 3/1/17.

Parent or Legal Guardian's Name (please print)_____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

_____ _____
Signature of Parent or Legal Guardian Date Signed

I authorize the doctor and his staff to contact me by ____phone ____email ____mail *(check all that apply)*

****

If the patient or the patient's parent/legal guardian did not sign above, staff member must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and what efforts were used to obtain the signature.

Notice of Privacy Practices effective 3/1/17 given to individual on _____ (date)

☐ In Person ☐ Email ☐ Mail ☐ Other_____

Reason patient or patient's parent/legal guardian did not sign this form:

☐ Did not want to sign
☐ Did not respond after more than one attempt
☐ Other_____

_____ _____
Staff Member's Name (please print) Title

_____ _____
Signature of Staff Member Date Signed