## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**For the office of Dr. Paul Cloninger, D.D.S., P.A.**

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting my office.

If you have any questions about my Notice of Privacy Practices, please contact Gina Dellinger.

I acknowledge receipt of the Notice of Privacy Practices of Dr. Paul H. Cloninger.

Signature:_____ Date: _____
(patient/parent/guardian)

## INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including mailing/phone call. However, because of incorrect information I was unable to obtain my patient's acknowledgement.

Signature of HIPAA coordinator: _____ Date:_____