

# Matthew J. Busch, D.D.S., Ltd.

*Your Privacy Is Important to Us*

## Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Matthew J. Busch, D.D.S., Ltd. I hereby authorize, as indicated by my signature below, Matthew J. Busch, D.D.S., Ltd. to use and to disclose my protected health information for any necessary clinical, financial, and insurance purposes.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Please check your preferred means of communication:

- You may contact me at my home telephone number \_\_\_\_\_
- You may contact me on my mobile telephone number \_\_\_\_\_
- You may contact me on my work telephone number \_\_\_\_\_
- You may send me an unencrypted email/text message at: \_\_\_\_\_
- Other \_\_\_\_\_

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
2. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
3. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
4. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_

\* \* \*

### For Office Use Only:

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify) \_\_\_\_\_

Staff Person Initials \_\_\_\_\_