James A. Williams, D.D.S., P.A.
619 N. First Street
Jacksonville, AR 72076
501-982-5384

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that my information may be shared with those I have listed below:

1._____

2._____

3._____

You may contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

_____ **I decline a copy of the HIPAA Notice of Privacy Practices.**

PATIENT OR PERSONAL REPRESENTATIVE

Signature: _____ Date: _____

Name: (Please Print) _____

Relationship to Patient: _____