Southern Indiana Dental Care
111 Heritage Square
Sellersburg, Indiana 47172

Dear Patient,

In order for us to stay within the HIPAA guidelines, please list below anyone that you authorize us to disclose information to regarding your Protected Health Information. It is not mandatory that you list anyone. **(You do not need to list any of your doctors).**

	Name	**Relationship**
1.	_____	_____
2.	_____	_____
3.	_____	_____

Do we have your permission to leave information on your **answering machine** or **voicemail** if we are unable to reach you? ____ Yes ____ No

What is the best number to contact you at _____ .

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient's Signature Date

HIPAA PRIVACY FORM 2

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.
Please Print Name

_____ _____
{Signature} of patient {Date}