SCHAEFER DENTAL GROUP

ACKNOWLEDGMENT 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.

☒ I am the patient

☐ I am a parent or legal guardian of the patient

☐ Other_____

I hereby authorize the release of my information to the following person(s):

Name Michael Alan Bishop (Jr.)	Phone# (517) 775-4916
Name	Phone#
Name	Phone#
Name	Phone#

I have received a copy of this office's Notice of Privacy Practices for myself or on behalf of my dependent.

Michael Alfred Bishop (Sr.)

(Please print patient name)

Michael Bishop 10/13/21

(Signature of patient or legal guardian) *(Date)*

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

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other: _____

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Margaret Bishop

(Please print patient name)

Michael A. Bishop 10/13/21

(Signature of patient or legal guardian) *(Date)*

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