RECEIPT OF NOTICE OF PRIVACY PRACTICES
For
Brodhagen Dental Care

Patient (Please Print – First and Last Name): _____ d/o/b_____
I authorize Brodhagen Dental Care to discuss my personal health information with _____. This authorization is valid until I choose to rescind it.
(Please Print – First and Last Names)

My signature on this form acknowledges that I have received a copy of **Dr. Mark A. Brodhagen's Notice of Privacy Practices**. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Dr. Mark A. Brodhagen and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

_____ _____
Patient's Signature (unless a minor) Date

_____ _____
Signature of Patient's Representative Date
if patient is unable to sign

TO BE COMPLETED BY DENTAL OFFICE IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of the Notice of Privacy Practices?
☐ **Yes** ☐ **No**

2. Briefly describe the efforts made to obtain the patient's acknowledgement of receipt of the Notice and explain why the patient was not able or unwilling to sign this form: _____
_____
_____
_____