

\_\_\_\_\_ (ofc) 817.800.9634 (cell) wjs@drstarck.com www.drstarck.com

**ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received a copy of William J. Starck, DDS's Notice of Privacy Practices effective 3/1/17.

Patient's Name (please print) \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date Signed

\*\*\*\*\*

I am a parent or legal guardian of \_\_\_\_\_ (patient's name). I have received a copy of William J. Starck, DDS's Notice of Privacy Practices effective 3/1/17.

Parent or Legal Guardian's Name (please print) \_\_\_\_\_

Relationship to Patient:       Parent                       Legal Guardian

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date Signed

I authorize the doctor and his staff to contact me by \_\_\_ phone \_\_\_ email \_\_\_ mail (check all that apply)

\*\*\*\*\*

If the patient or the patient's parent/legal guardian did not sign above, staff member must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and what efforts were used to obtain the signature.

Notice of Privacy Practices effective 3/1/17 given to individual on \_\_\_\_\_ (date)

In Person    Email    Mail    Other \_\_\_\_\_

Reason patient or patient's parent/legal guardian did not sign this form:

- Did not want to sign
- Did not respond after more than one attempt
- Other \_\_\_\_\_

\_\_\_\_\_  
Staff Member's Name (please print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature of Staff Member

\_\_\_\_\_  
Date Signed