

University Oral Surgery Center
Ramin Shabtaie, DDS, Inc
Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____ [full name], have received (or have been offered) a copy of the Notice of Privacy Practices for Ramin Shabtaie, DDS, Inc. A copy of our Notice of Privacy Practices is available on our website for your review www.unioralsurgery.com.

By signing this form, I am giving this office my consent to use and disclose health information about the patient named below for treatment, collection of payment and healthcare operation purposes.

Patient's Name _____

Signature of authorizing party _____

Date _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient (parent/guardian): _____

For Program 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 (Please Specify): _____