DAVID CHECKOFF, D.M.D.
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Orthodontic Associates

ACKNOWLEDGEMENT OF AWARENESS AND/OR RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I (print) _____, (Date of Birth:_____) have read the "Notice of Privacy Practices (HIPAA)" from Orthodontic Associates.

Patient Signature:_____ Today's Date:_____

I authorize my personal dental health information to be disclosed to the following individuals, if necessary: (This is for Family and/or Friends; Treating Doctor names are not needed here.)

Name _____ relationship_____ phone_____

Name _____ relationship_____phone_____

Name _____ relationship_____phone_____

I request that you attempt to contact me with confidential communications about my dental care in the following ways:

May we email you?	YES	NO
May we text you?	YES	NO
May we leave a message on home answering machine?	YES	NO
May we leave messages at place of employment?	YES	NO
May we leave message on cell phone?	YES	NO

For office use only:

In lieu of patient signature above, I, _____, a Staff member of Orthodontic Associates, state that:

Patient name Printed_____ has been made aware of/given our current "Notice of Privacy Practices (HIPAA)."

Staff Member Signature_____ Date_____