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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

The undersigned acknowledges receipt of a copy of the currently effective **Notices of Privacy Practices** for **Gulf Coast Endodontic Associates** today _____ (Date). A copy of this signed, dated acknowledgement shall be effective as the original.

Patient Full Name

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority.

Please list whom you would like to have access to your records:

_____ relation to you: _____

_____ relation to you: _____

Thank you for your cooperation. If you have any questions about this form or the attached notice please contact our privacy officer.

Office Use Only

As a privacy officer, I attempted to obtain the patient's (or representatives) signature on the acknowledgement but did not because:

- ___ It was emergency treatment
- ___ I could not communicate with the patient
- ___ The patient refused to sign
- ___ The patient was unable to sign because _____
- ___ Other (please describe) _____

Signature of Privacy Officer

