# Robert F. Faulkner, D.D.S., Inc.

Maxillofacial Prosthodontist

## ACKNOWLEDGEMENT OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment"

I, _____, acknowledge that this practice has a Notice of Patient Privacy Practices and hereby give my consent to your use and disclosure of my protected health information to provide treatment, payment and health care operations.

_____

Patient/Parent Signature

_____

Date

A copy of our Privacy Practice is available in the office.

**Practice Purposes Only** - Patient Refusal

Our practice attempted to obtain written statement for Notice of Privacy Practices. Receipt could not be obtained for the following reason:

- ☐ Patient refused to sign notice
- ☐ An emergency occurred and prevented us from obtaining
- ☐ Other (please specify below)

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