



D. Scott Trettenero, DDS
 13340 Parker Commons Boulevard #104 • Fort Myers, FL 33912
HIPAA Notice of Privacy Practices (“Acknowledgement”)

I acknowledge that I have received a copy of this Dental Practice’s **HIPAA Notice and Privacy Practices**.

Patient Name _____ on _____
 (Please Print) (Date)

Patient Signature / Or Signature of Personal Representative

Sign for Patient (check one): ___ Parent ___ Guardian ___ Power of Attorney ___ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement. You also are entitled to a copy of this consent after you sign it.

Revocation of Consent (REFUSAL)

I *revoke* my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice or revocation. I understand that you may decline to treat or continue to treat me after I have revoked my consent.

 Patient Signature / Or Signature of Personal Representative Date

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of our HIPPA policy, but it could not be obtained because:

- o An emergency prevented us from obtaining acknowledgement.
- o A communication barrier prevented us from obtaining acknowledgement.
- o The individual was unwilling to sign.
- o Other: _____

Office Staff Signature _____ Date _____