HIPAA PRIVACY PRACTICE ACKNOWLEDGEMENT

The Notice of Privacy Practices Act was provided by Dr. Sophia Tan, DDS and I have been given the opportunity to review it.

Patient Name _____ DOB ___/___/_____

Signature _____ DATE ____/___/_____
(Parent/Legal Guardian)

METHODS OF CONFIDENTIAL COMMUNICATIONS

Your authorization is required for confidential communications. Except as described in the Privacy Practices form, we will not use or disclose your protected health information (PHI), unless you request, in writing, your method of confidential communications by alternative means, such as sending correspondence to your office at work instead of your home. Please be advised that certain forms of communication(s) may not be secure and there is a risk it could be read by a third party.

I wish to be contacted in the following methods (please check all that apply):

- ☐ HOME Phone _____
  - ☐ Leave a message with detailed information
  - ☐ Only leave a call back number
- ☐ WORK Phone _____
  - ☐ Leave a message with detailed information
  - ☐ Only leave a call back number
- ☐ OTHER Phone _____
  - ☐ Leave a message with detailed information
  - ☐ Only leave a call back number
- ☐ WRITTEN CORRESPONDENCE
  - ☐ Mail to my HOME address
  - ☐ Mail to my WORK address _____
- ☐ FAX Communication
  - ☐ FAX to this number _____
- ☐ EMAIL (please print clearly) _____
  - ☐ Correspondence via email with detailed information

I have given the office of Sophia Tan, DDS the authority to do so by signing on my/patient's behalf.

Signature _____ Date ____/____/_____
(Parent/Legal Guardian)