River City Oral & Maxillofacial Surgery

Notice of Privacy Practices

ACKNOWLEDGEMENT OF REVIEW

Date: _____

I have reviewed the River City Oral & Maxillofacial Surgery (RCOMS) Privacy Practices (version effective December 31, 2018), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please indicate your relationship to the patient and print and sign your name in the space below.

_____

Relationship to Patient (Print)

_____ _____

Personal Representative (Print) Personal Representative Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please be specific):

_____

_____

_____ _____

Employee Signature Date