Zellerbach Family Dental
6886 Indiana Ave., Ste B
Riverside, CA 92506
(951) 686-2565

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign this Acknowledgement****

I, _____, have received a copy of the Zellerbach Family Dental Notice of Privacy Practices.

_____ Please print name

_____ Signature

_____ Date

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name: _____

Relationship to Patient: _____

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact at:

Telephone: 951-686-2565 Fax: 951-686-4565

Email: info@zellerbachfamilydental.com

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

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
___ Communications barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (please specify)
_____
_____

Acknowledgement received by: _____