David Stanphill, D.D.S.
Stephanie Cervetto, D.D.S.

HIPAA – Acknowledgement of Receipt of NOTICE OF PRIVACY PRACTICES

_____Patient Name

I, _____ (print name), have been presented with the Notice of Privacy Practices of David Stanphill, D.D.S and Stephanie Cervetto, D.D.S., and have been offered a copy of such policy to keep for my records.

_____I hereby acknowledge that I have been offered a copy of the policy.

Signature_____ Date_____

.....

Privacy Permissions (Initial all that apply and complete where necessary)
Due to privacy laws, if people accompanying you or your child are not listed no information, including appointments, will be given out.

_____You may call and leave only a call back message with the following persons or numbers:

_____

_____

_____

_____You may call and leave a detailed message with the following persons or numbers:

_____

_____

_____

_____Please allow the following persons to obtain school permission slips or discuss dental treatment:

_____

_____

_____

_____I do **NOT** want any information regarding myself or my children's records, appointments, or dental treatment shared or given to the following persons:

_____

_____

_____

_____

Due to privacy laws, if people accompanying you or your child are not listed no information, including appointments, will be given out.