GRANDE DENTAL CARE
Dr. Marcos A. Grande, DDS PLLC
General, Cosmetic, and Implant Dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement and authorization. In refusing, we *may not be allowed* to process your insurance claims.

The undersigned acknowledges a receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. This form is used to obtain acknowledgement of receipt of our Privacy Practices or to document our good faith effort to obtain that acknowledgement. A copy of this signed, dated document shall be as effective as the original.

Printed name of patient: _____ Date: _____

Signature of patient or representative: _____

Printed name of representative: _____ Relationship: _____

Consent for Release of Limited Information

I authorize the office of Dr. Marcos A. Grande, DDS PLLC to release limited information about me to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Printed name of patient or representative: _____

Signature of patient or representative: _____ Date: _____

>>Office Use Only<<

I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not due to:

- ❑ Patient refused to sign
- ❑ Communication barriers prohibited us from obtaining Acknowledgement
- ❑ Emergency situation prevented us from obtaining Acknowledgement
- ❑ Patient was unable to sign due to: _____

Signature of office representative: _____ Date: _____