675 E Nicollet Blvd, Ste 120
Burnsville, MN 55379
952-892-7700

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received or been offered a copy of this office's Notice of Privacy Practices.

Print Patient Name____

Patient or Guardian Signature____

Guardian Name____

Relationship to Patient____

Date___________________________________

I give permission Northstar Dental Clinic to VERBALLY discuss my treatment, scheduling/ appointment information, billing, and payment information with the following people:

Name:____Phone #_________________

And

Name:____Phone #_________________

I understand I have the right to revoke my permission at any time. I understand I must notify Northstar Dental Clinic in writing if I want to revoke my permission.

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)____