Jeremy Haider, DMD, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You have the right to refuse to sign this acknowledgement****

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any questions or complaints, I may contact:

Jeremy Haider, DMD
2600 12th St SE
Salem, OR 97302
503-363-6525

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Signature: _____ Date: _____

Printed Name: _____ Relationship to patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

_____Patient refused to sign (date of refusal)_____/_____/_____.

_____Communication barriers prohibited obtaining an acknowledgment.

_____An emergency situation prevented us from obtaining an acknowledgment.

_____Other_____

Attempt was made by:_____Date:_____