Robert G. Coseo DDS
65 Camp Street
Hyannis, Ma 02601
508-775-9977

ACKNOWELDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form acknowledge receipt of the notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I received a copy of this office's Notice of Privacy Practices.

Please print name here _____
Signature _____
Date _____

___ I authorize Distinctive Dentistry to release any information pertaining to my dental treatment, dental appointments and/or my dental account; to my spouse, parent, guardian, child, caregiver or other (listed below)

_____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

__ The patient refused to sign.
__Due to an emergency situation it was not possible to obtain an acknowledgement.
__We weren't able to communicate with the patient
__Other (please provide specific details).

Employee
signature_____Date_____