ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES
FOR:
Dr. Enrique Oltra Esplugues, DDS, MS

We are required by law to maintain the privacy of, and provide individuals with, this notice of legal duties and privacy practices with respect to protected health information.
Your signature below only acknowledges you have received this notice of our privacy practices.
*You may refuse to sign this acknowledgement. *

PRINT NAME: _____ E-MAIL:_____
SIGNATURE: _____ DATE: _____

The following list involves the options available to you, as a patient for us to contact you regarding your health information or appointment confirmation.
Please circle yes or no and initial each option.

I would like to be contacted by phone for all health information and appointments. You may leave a message on my answering machine or service.

YES NO **Your initials _____**

It is agreeable to me for messages regarding my health information and appointments be left with family members that may answer my phone.

YES NO **Your initials_____**

It is agreeable to me for my health care provider to discuss my condition and treatment with the following individual (s):

_____ _____ _____ **Your initials_____**

_____For Office Use_____

Written acknowledge could not be obtained because:

___ Individual refused to sign
___ Emergency situation prevented this from being signed
___Other (please specify)