

**Emily Johnson DDS, LLC  
Magnolia Family Dental**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*You may refuse to sign this acknowledgement.*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices  
Print Name

\_\_\_\_\_  
Signature Date

**PATIENT COMMUNICATIONS (HIPAA)**

By Law, without your authorization, Magnolia Family Dental CANNOT communicate with:

- your spouse
- your parents (if you are age 18 or over)
- your adult children or caregivers

Magnolia Family Dental may need to communicate with your family or caregivers in the following circumstances:

- scheduling appointments
- discussing treatment needed or performed
- confirming appointments
- account or financial information

**Please indicate below the names of people who we may communicate with regarding your appointment, medical/dental or account information:**

- My Spouse \_\_\_\_\_
- My Adult Children \_\_\_\_\_
- My Parents \_\_\_\_\_
- My Caregiver \_\_\_\_\_
- Other \_\_\_\_\_

- I do not wish to allow any of my information to be shared with anyone, including my spouse or any other family member and/or guardian.

**Patient Name (printed)** \_\_\_\_\_

**Patient/ Parent/ Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

\_\_\_ Individual refused to sign    \_\_\_ Communication Barrier prohibited obtaining the acknowledgement

\_\_\_ An emergency situation prevented us from obtaining acknowledgement    \_\_\_ Other (please specify)

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