Dr. Jo Ann Thiel, DDS, PA

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices
This practice reserves the right to modify the privacy practices outlined in this notice

I have received a copy of the "Notice of Privacy Practices"

Name of Patient (Print)

Signature of Patient **Date of Signature**

Signature of Representative **Relationship to Patient**
(Required if patient is a minor or an adult who is unable to sign this form)

Request for Confidential Communication of your protected health information

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Please circle your response to the following:

May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answers your calls?

YES NO NA

May we leave messages on a voice mail at work, home or cell?

YES NO NA

May we discuss your appointments/treatment with your spouse/significant other?

YES NO NA

If over age 18, may we discuss your appointments/treatments with your parent(s)/guardian?

YES NO NA

May we discuss your appointments/treatment with your children?

YES NO NA

Please list anyone else that is authorized to receive your health information:

Please be aware that you must inform us in writing if you wish to change the manner in which this office communicates with you.