

Acknowledgement of Receipt of Notice of Privacy Practices

ASSOCIATED DENTAL CARE OF HELENA, PLLC
121 N. LAST CHANCE GULCH, STE E
HELENA, MT 59601
406-443-5526

* You May Refuse to Sign This Acknowledgment*

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

Print Name: _____

Signature: _____

Date: _____

I give my permission for Associated Dental Care of Helena to disclose information regarding my treatment to the following person (s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

For Office Use Only

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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