

# RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

**Chami Dental**  
**425 Madison Ave Suite 1800J**  
**New York, NY 10017**

## Acknowledgement

I, \_\_\_\_\_, hereby acknowledge that I have received and reviewed a copy of **Chami Dental's** *HIPAA Notice of Privacy Practices*.

I understand that **Chami Dental's** *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **Chami Dental's** revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about **Chami Dental's** *HIPAA Notice of Privacy Practices*, I may contact **Dr. Ben Elchami** at 212-868-9321.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Chami Dental** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Chami Dental's** privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Dr. Ben Elchami, noted above, for assistance.

_____	_____
Patient Signature	Date
_____	_____
Signature of Personal Representative	Print Name of Personal Representative
	_____
	Relationship of Personal Representative to Patient

## FOR OFFICE USE ONLY

**Chami Dental** made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, **Chami Dental** was unable to obtain a signed Acknowledgement for the following reason(s):

- Refusal to sign Acknowledgement on \_\_\_\_\_, 20\_\_\_\_\_.
- Communications barriers prohibited us from obtaining a signed Acknowledgement.
- An emergency situation prohibited us from obtaining a signed Acknowledgement.
- Other (Describe): \_\_\_\_\_

_____	_____	_____
Date Received	By	Patient ID