

Elli Emmons, DDS

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.

Signature

Date

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____
Please print

Date of Birth: _____

I request that all communications to me by **Dr Elli Emmons, DDS** and/or its staff be handled in the following manner:

- Written Communications: Address to: _____

- Oral Communications: Call: _____

May we leave a message?

YES ____ NO ____

If the address provided above is not your home address OR is not a street address, please provide us with a street address for purposes of ensuring payment:

Patient Signature

Date

(This form is educational only, does not constitute legal advice, and covers only federal, not state law in effect or proposed as of March 27, 2002. Subsequent law changes may require Form Revision)