Metrowest Prosthodontics

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices of Metrowest Prosthodontics, and have been offered the opportunity to review it and ask any further questions about my rights to the maintenance of the security of my Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) and corresponding HITECH Legislation.

_____

Patient's Name or Name of Guardian or Personal Representative

_____

Signature

_____

Date