

**Grape Lakes Family Dental, PC**  
2 South Main Street, P O Box 10  
Manchester, NY 14504  
(585) 361-9777

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**Purpose:** This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. If you wish to receive a copy of the Privacy Practices, please let our front desk know.

**\*\*\*You May Refuse to Sign this Acknowledgment\*\*\***

I have reviewed a copy of this office's Notice of Privacy Practices and I understand that I may request a copy at any time.

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

Date\_\_\_\_\_

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**Authorization to Release Information**

**Purpose:** This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself.

I authorize the following person(s) below to have access to information covered under the Privacy Practice regarding myself.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)