



Receipt acknowledgement of notice of privacy practices

You, the patient, may refuse to sign this acknowledgment

Scott R. Walker, D.M.D., P.C. keeps a record of the healthcare services we provide you. You can ask to see and copy that record. You also can ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You can see your record or get more information about it by contacting Scott R. Walker, D.M.D., P.C.'s designated Privacy Official.

Our Notice of Privacy Practices describes in more detail how your health information can be used and disclosed, and how you can access your information.

By my signature below, I affirm that I have received and read a copy of Scott R. Walker, D.M.D., P.C.'s privacy, security and breach notification policies and procedures.

I further understand that I may ask Scott R. Walker, D.M.D., P.C.'s Privacy Official any questions that I may have about these policies and procedures.

_____ Date _____
Patient/legally authorized representative

_____ Relationship _____
Printed name if signed on behalf of patient

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:

- Patient refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other
