UDA DENTAL
UNIVERSITY DENTAL ASSOCIATES

SCOTT F. TUCKER DDS, MS, PA

PRIVACY NOTICE
PATIENT ACKNOWLEDGMENT OF RECEIPT

I, _____ have been presented with the Privacy Notice of University Dental Associates,
(PRINT FULL LEGAL NAME)
Scott F. Tucker, DDS, PA and have been given a copy of the Notice to keep for my records.

_____ (initial here) I understand that UDA may use and disclose my protected health information (PHI)) for treatment, payment and healthcare operations.

_____ (initial here) I understand my rights regarding the use of my protected health information (PHI) and further understand that UDA will not disclose my PHI for reasons other than treatment, payment and healthcare operations without my written consent.

_____ (initial here) I understand that UDA will not use my protected health information (PHI) for any other uses not explained in the Privacy Notice without my consent and that I will be notified if there is a breach regarding my PHI.

_____ (Initial Here) I hereby acknowledge that I have read the Privacy Notice and understand its terms and conditions

OR

_____ (Initial Here) I hereby refuse to acknowledge receipt of the Notice of Privacy Practices and refuse to read or acknowledge any of the terms and conditions of the Notice. I understand that even though I may refuse to sign this acknowledgment, University Dental Associates may still provide treatment to me.

_____ **OR** _____
Patient Signature Date Personal Representative/Relationship Date

FOR OFFICE USE ONLY BELOW

I, _____, acting as an official employee representative for
(PRINT FULL LEGAL NAME)
University Dental Associates, Scott F. Tucker, DDS, PA attempted to obtain the written acknowledgment of receipt of the Privacy Notice on (date of attempt) _____, but the acknowledgment could not be obtained because:

_____ (Initial Here) Patient or Patient's legal representative refused to sign.

_____ (Initial Here) Patient or Patient's legal representative could not be sufficiently communicated with to obtain acknowledgment.

_____ (Initial Here) Emergency circumstances prevented securing acknowledgment.

_____ (Initial Here) Other Reason(s) (Please Specify _____)

Signature of UDA Employee Representative (Print Name) Date

****** PLACE THIS SIGNED FORM IN THE PATIENT'S PERMANENT RECORD ******