Dr. Robert Eversole, DDS, PC.
Dr. Matthew Sullivan, DDS
1315 W. Westridge Parkway
Greensburg, IN 47240

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 and understand that the Notice describes how my protected medical/dental information may be used and disclosed and how I may get access to this information. I have been given the opportunity to take a copy of the Notice of Privacy Practices for further review.

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AUTHORIZATION TO RELEASE INFORMATION TO THIRD PARTY

I authorize Robert Eversole DDS, PC to release information to third parties, as follows: _____ **NONE**

Name: _____ Relationship_____

Name: _____ Relationship_____

Name: _____ Relationship_____

****

_____
Please Print Name

_____
Signature

_____
Date

****

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)_____