
Dr. Robert Eversole, DDS, PC.
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.

**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) _____