MIDDLE TENNESSEE
PROSTHODONTICS

**Bryan McLaughlin,** DMD, MPH, FACP
**Nisha Patel,** DMD, MS, FACP
**Stephen Peterman,** DDS, FACP

# 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.**

Print Name: _____

Signature: _____

Date: _____

Please list any person or persons we may release your medical information to:

_____

_____

_____

Sign: _____ 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 acknowledgement

☐ Other (Please Specify)

_____

_____

_____

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# 2026 HIPAA FORM

## MEDICAL INFORMATION COMMUNICATION

Patient: _____ DOB: _____

As our patient, we may need to communicate with you when you are not in the office. To maintain your privacy, please indicate your contact preferences.

## LIST PHONE NUMBER(S) YOUR PREFER WE USE TO CONTACT YOU

Primary Phone Number: _____ Check one: ☐ Cell ☐ Home

Secondary Phone Number: _____ Check one: ☐ Cell ☐ Home

How do you want to receive the automated appointment reminder? Check one: ☐ Phone ☐ Text ☐ Both

If we need to contact you directly, may we leave a voicemail message? Check one: ☐ Yes ☐ No

If you want to sign up for the patient portal, please provide your email address: _____

**NOTE:** *If you currently have the portal, please note that messages from the office may be sent to you directly through this portal!*

## TELL US WITH WHOM WE MAY SPEAK

Without Permission, we **WILL NOT** release any medical information to anyone other than you.

☐ **DO NOT** release medical information to anyone **other than myself.**

☐ ] I authorize the individuals listed below to be contacted in case of an emergency or to receive any medical information pertaining to me:

| NAME | RELATIONSHIP TO CLIENT | TELEPHONE NUMBER |
|---|---|---|
| | | |
| | | |
| | | |

*I assume responsibility to inform the practice of changes in my phone number(s) or my preferences in the release of my medical information.*

_____ _____
Signature of Patient or Patient's Legal Representative Date