

# Dental Practice of: Mark R. Morin, D.D.S., P.C.

## Acknowledgement of Receipt of this Practices Privacy Notice

I acknowledge that I have received, and/or reviewed the notice of the Privacy practices of this office. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that this notice of the practices Privacy Practices is posted in the office where I can review it if desired.

\_\_\_\_\_  
Patient or Patient Representative or Parent of Patients under age 18

\_\_\_\_\_  
Date

(If patient representative signs above, please describe the relationship to the patient.)  
\_\_\_\_\_

## Documentation of "Good Faith Effort"

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

The patient presented for treatment on this date, and was provided the practices Privacy Notice. A good faith effort was made to obtain written acknowledgement of receipt. A written acknowledgement was not obtained because:

\_\_\_\_\_ Patient refused to sign, with the reason \_\_\_\_\_

\_\_\_\_\_ Patient is unable to sign due to: \_\_\_\_\_

\_\_\_\_\_ There was medical emergency preventing timely signature, and an attempt will be made to obtain acknowledgement later

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_  
Signature of employee completing this form

Mark R. Morin, D.D.S., P.C.  
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