

**Sonja A. Jarmoszuk, DDS, LLC**  
**21590 Center Ridge Road, Suite B**  
**Rocky River, Ohio 44116**

***ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES***

**Purpose:** This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**You May Refuse to Sign This Acknowledgement**

I, \_\_\_\_\_, have received or been offered a Notice of Privacy Practices for the office of Sonja A. Jarmoszuk DDS, LLC (available at [drjarmoszuk.com](http://drjarmoszuk.com) or at office).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***AUTHORIZATION TO RELEASE INFORMATION***

**Purpose:** This form is used to obtain authorization to release information regarding your child covered under the Privacy Act to people other than yourself.

I, \_\_\_\_\_, authorize the following person(s) to have access to information covered under the Privacy Practice regarding my child/children (*Please list all persons who might bring your child to an appointment, schedule or change an appointment time, listen to information regarding your child's dental care or treatment*).

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Relationship to child

**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)

\_\_\_\_\_  
\_\_\_\_\_