FORT WAYNE
PROSTHODONTICS
Ryan Zimmerman DMD, FACP

NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, understand this office recognizes
(Please Print Name)
and adheres to the regulations set forth by the Notice of Privacy Practices.

_____
Signature

_____
Date

I hereby authorize the following listed person(s) to obtain my medical information:

_____ _____

_____ _____

_____ _____

For Office Use Only

We attempted to obtain written acknowledgement 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)

_____

_____

4205 Hobson Court, Fort Wayne, Indiana 46815
phone: 260-486-8778 email: office@fortwaynepros.com