# FORT WAYNE PROSTHODONTICS

## Ryan Zimmerman DMD, FACP

**Acknowledgment of Receipt of Notice of Privacy Practices**
**Effective Date of Revised Notice: February 16, 2026**

**Patient Name (printed) :** _____ **Date of Birth:**_____

I acknowledge that I have been offered and/or received a copy of the Notice of Privacy Practices for **Fort Wayne Prosthodontics, Inc.**
The Notice of Privacy Practices explains how my medical and dental information may be used and disclosed for purposes of treatment, payment, and healthcare operations. It also describes my rights regarding my protected health information, including my right to:

- Inspect and copy my health information
- Request amendments to my health information
- Request restrictions on certain uses and disclosures
- Request confidential communications
- Receive an accounting of disclosures
- Obtain a paper copy of the Notice upon request
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I understand that **Fort Wayne Prosthodontics, Inc.** reserves the right to change its Notice of Privacy Practices and that a current copy will be available in the office and upon request.

**Authorization to Discuss My Health Information**

I authorize **Fort Wayne Prosthodontics, Inc.** to discuss my protected health information with the following family members, friends, or other individuals:

| Name | Relationship | Phone/Contact Info |
|---|---|---|
| | | |
| | | |
| | | |

I understand I may revoke this authorization at any time by notifying the office in writing.

**Patient Signature:** _____ **Date:**_____

If signed by personal representative, please indicate relationship to patient:

**Relationship:** _____
**Printed Name of Personal Representative:**_____

**For Office Use Only**

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Patient refused to sign
☐ Patient unable to sign
☐ Emergency situation
☐ Other: _____

**Staff Name:** _____ **Date:**_____

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