



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

****You may refuse to sign this acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices

(Please Print Name)

(Signature)

(Date)

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends or other relations regarding your dental treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (Including Spouse or Significant other.)

Name

Relation

Phone #

Name

Relation

Phone #

Name

Relation

Phone #