ACKOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICES

SECTION A:
Patients Name:
Address:
Telephone Number:
Social Security Number:

I, , acknowledge that I received a Notice of Privacy Practices from Centennial Hills Dental Health Center.

Patient Signature: Date:

SECTION B:
If a personal representative signs this authorization on behalf of the individual, please complete the following:

Signature: Date:
Personal Representatives Name:
Relationship to Individual:
Address:
Telephone Number:

SECTION C:
If you decline to sign this form, please state the reason why:

Signature: Date:
Name:

Witness Signature: Date:
Witness Name: