Acknowledgement of Receipt of Notice of Privacy Practices

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practice (NPP). It describes how your health information will be used and disclosed along with your rights as a patient of North Shore Dental LLC.

By signing below, you acknowledge receipt of North Shore Dental LLC Notice of Privacy Practices.

_____

Print Patient's Name

_____ _____

Patient's Signature or Personal Representative's Signature **Date**

If signed by a Personal Representative, Please describe your relationship to the patient:

_____

If patient refuses to sign, notate:

_____ _____

Date provided to patient **Time**

Reason for refusal:

_____
_____
_____

_____

Initials of individual who provided NPP to patient