CITY DENTAL P.C.

SECTION A: The Patient.
Name: _____
Address: _____
Telephone: _____E-mail_____
Patient Number: _____Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:
Personal Representative's Name: _____
Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____
_____
_____
Describe the reason why the individual would not sign this form: _____
_____

SIGNATURE.
I attest that the above information is correct.

Signature: _____Date: _____
Print name: _____Title: _____
Include this acknowledgement of receipt in the individual's record.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE