Acknowledgement of receipt of Privacy Practice Notice for

Carrollwood Dental Group

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of the Notice of Privacy Practices.

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Please print your name here

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Patient signature – Parent if minor child Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign
- We were not able to communicate with the patient
- Other (Please provide specific details)

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Employee Signature Date