Amarillo Dental Works

www.amarillodentalworks.com

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Patient Name: ______________________ ______________________ ___ ________________

Last First MI Preferred Name

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

Signature of patient, parent, or guardian:

Signature ____ **Date** ________

If personal representative signs this on behalf of the patient, please complete the following:

Personal Representative's Name____________________________________

Relationship to Patient____

Response Date: ___________