

# Family Dentistry



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## Healthcare Notice of Privacy Practices Acknowledgement

I hereby acknowledge that I have received a copy of the Healthcare Notice of Privacy Practices. This acknowledgement does not signify that I have read, understand, or agree with all of the uses and disclosures listed in the Notice, only that I have received a copy of this Notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(if signed by a personal representative of the patient, please complete the following)

Personal Representative's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Parent \_\_\_\_\_ Legal Guardian \_\_\_\_\_ Holder of Medical Power of Attorney

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- Patient was unable to sign  
Reason: \_\_\_\_\_
- Patient refused to sign
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Employee Name: \_\_\_\_\_

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