

**ACKNOWLEDGEMENT OF RECEIPT OF
PRIVACY PRACTICE NOTICES**

SECTION A:

Patients Name: _____
Address: _____
Telephone Number: _____
Social Security Number: _____

I, _____, acknowledge that I received a Notice of Privacy Practices from Centennial Hills Dental Health Center.

Patient Signature: _____ Date: _____

SECTION B:

If a personal representative signs this authorization on behalf of the individual, please complete the following:

Signature: _____ Date: _____
Personal Representatives Name: _____
Relationship to Individual: _____
Address: _____
Telephone Number: _____

SECTION C:

If you decline to sign this form, please state the reason why:

Signature: _____ Date: _____
Name: _____

Witness Signature: _____ Date: _____
Witness Name: _____