Style Your Smile Family & Cosmetic Dentistry
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

THIS FORM IS USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT.

I, ______________________________________ have reviewed that Notice of Privacy Practices
(Parent/Guardian Name)
from *Style Your Smile Dentistry, LLC* for ______________________________________
(Child's Name)
and also give my permission to allow disclosure of treatment, dental health and financial matters to the following person(s) appointed below:

Name of Person: ______________________	Name of Person: ______________________
Relationship to Patient: ______________	Relationship to Patient: ______________
Address: ____________________________	Address: ____________________________
____________________________	____________________________
Phone: ______________________________	Phone: ______________________________

Patient: ______________________________ Date: ______________________________
PARENT/GUARDIAN SIGNATURE