Dr. Monica Rajurs, DMD
Family & Cosmetic Dentistry

Acknowledgement of Receipt of this Patient Privacy Notice

I acknowledge that I have received, and/or reviewed the notice of the privacy practices of this office. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that this notice of the Patients Privacy Practices is posted in the office where I can review it if desired.

_____ _____

Patient or Patient Representative or Parent of patients under age 18 Date

(If patient representative signs above, please describe the relationship to the patient).

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