Style Your Smile Family & Cosmetic Dentistry S. Alexander DDS

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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,PRINT NAME from Style Your Smile Dentistry, LLC	
I 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:	
Phone:	Phone:
Patient:SIGNATURE	Date: