PATIENT NAME: _____

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Family Dentistry
11600 Manchester Road
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Patient Acknowledgement of Receipt of the Notice of Privacy Practices

By signing this form, I am acknowledging receipt of the Notice of Privacy Practices.

I have the right to review the Notice of Privacy Practices prior to signing this form. This office reserves the right to revise its Notice of Privacy Practices at any time. A copy of such revisions is available upon request and will also be available on our website. www.RonaldLTriplettDMD.com

_____
Signature of Patient or Legal Guardian

_____
Print Name of Legal Guardian

_____
Print Name of Patient Date