River City Dentistry D.D.S. P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Print Patient's Name

_____
Signature Patient/Parent or Guardian

_____
Date

I give permission for River City Dentistry's office to give my personal information to the following people:

_____ *Relationship:* _____

_____ *Relationship:* _____

_____ *Relationship:* _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ *Individual refused to sign*
____ *Communication barriers prohibited obtaining the acknowledgement*
____ *An emergency situation prevented us from obtaining acknowledgement*
_____ *Other (please specify)*