
Emily Graham, DDS.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

PLEASE REVIEW THIS ACKNOWLEDGEMENT AND SIGN BELOW AFTER YOU
HAVE RECEIVED THE INFORMATION AND INITIAL ONE OF THE FOLLOWING
FROM THE LIST SHOWN BELOW:

Patient Name: _____

Last

First

_____ I acknowledge that I have received and/or read and been offered a copy of the office's NOTICE OF PRIVACY PRACTICES AND RIGHTS. I have read the notice and I understand my privacy rights and the office's privacy policies.

_____ Patient refuses to sign the notice. Employee name and date _____.

_____ The patient is unable to sign the acknowledgement or is a minor. If the patient is a minor or represented by a personal representative, the authorized guardian/representative has signed below.

Signature _____

Date _____
