PITTSBORO SMILES
FAMILY DENTISTRY

RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You may refuse to sign this acknowledgement"

I, _____, have received a copy of this practice's Notice of Patient Privacy Practices and hereby give my consent to your use and disclosure of my protected health information to provide treatment, payment and health care operations.

_____
(Patient Name)

_____
(Patient/Parent Signature)

_____
(Date)

__Patient refused to sign

__An emergency occurred and prevented us from obtaining

__Other (Please specify)

_____

_____

_____