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Diplomate, American Board of Periodontology  
Periodontics and Dental Implant

**PATIENT ACKNOWLEDGEMENT OF RECEIPT  
NOTICE OF PRIVACY PRACTICES**

I have received (or have been offered) a copy of this office's Notice of Privacy Practices. By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Representative (if minor): \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

**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
- Communications barriers prohibited obtaining the acknowledgements
- An emergency situation prevented us from obtaining acknowledgements
- Other {Please Specify}: \_\_\_\_\_