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## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Secure Dental Notice of Privacy Practices. In this notice I was advised of how health information about me may be used and disclosed by Secure Dental. I was also advised how I may obtain a copy of this information and correct errors in my health information.

Print Name of Patient: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Signature of Patient or Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Personal Representative, if applicable: \_\_\_\_\_

Personal Representative's authority to act: \_\_\_\_\_  
(e.g., parent, guardian, power of attorney stating relationship to the individual making the request)

Acknowledgement Form  
Effective Date: February 16, 2012