SECURE DENTAL
Dentistry for a Healthy Smile

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: _____ *Date:*_____

Print Name of Personal Representative, if applicable: _____

*Signature of Personal Representative:*_____ *Relation to Patient:*_____
(e.g., parent, guardian, power of attorney stating relationship to the individual making the request)

Acknowledgement Form
Effective Date: October 2020