ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I acknowledge that I have received a copy of Dental Health Professional's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Please list the names of your family members or any other person that has your permission to have access to your personal health and account information:

Name	Relationship
_____	_____
_____	_____
_____	_____

Please return this form to:
Dental Health Professionals, P.O. Box 889, Cadillac, MI 49601