

## 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

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