

ELIZABETHTOWN DENTAL ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of Elizabethtown Dental
(print patient's name)
Associates Notice of Privacy Practices

(print patients name or name of parent or guardian, if patient is a minor)

(signature of patient or parent or guardian, if patient is a minor)

(date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- _____ Individual refused to sign.
- _____ Communications barriers prohibited obtaining the acknowledgement.
- _____ An emergency situation prevented us from obtaining acknowledgement.
- _____ Other (please specify below)

