



**ACKNOWLEDGMENT OF RECEIPT**  
**of the Notice of Privacy Practices of the**  
**Redfearn Family Dental**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Patient(s) Name: \_\_\_\_\_

\_\_\_\_\_

Patients Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

\_\_\_\_\_ The patient refused to sign.

\_\_\_\_\_ Due to an emergency situation it was not possible to obtain an acknowledgement.

\_\_\_\_\_ We weren't able to communicate with the patient.

\_\_\_\_\_ Other (*Please provide specific details*)

\_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_