

ACKNOWLEDGEMENT OF THE RECEIPT OF PRIVACY PRACTICES

l, _____

_____, acknowledge I have been provided a

reference copy of the HIPAA Notice of Privacy Policy and may request a copy of the policy.

PATIENT OR GUARDIAN NAME PRINTED

Furthermore, I understand that my health, insurance, and other personal information collected by Cary Prosthodontics will only be used as described in the aforementioned policy.

My signature indicates I have received, read, and understand that Cary Prosthodontics has communicated to me my rights under HIPAA.

PATIENT OR GUARDIAN SIGNATURE

DATE