

**ACKNOWLEDGMENT OF RECEIPT**  
**OF**  
**NOTICE OF PRIVACY PRACTICES**

I have acknowledged that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the notice.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
Signature

May we contact you by telephone for purposes of appointment reminders?    YES    NO

May we contact you by email for purposes of appointment reminders only?    YES    NO

May we leave information regarding laboratory or x-ray information at the telephone number provided to us?    YES    NO