ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, acknowledge that I have received a copy of *Apollonia Dental,P.A's* Notice of Privacy Practices. This Notice describes how *Apollonia Dental, P.A.* may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

X

Signature of Patient or Parent/Guardian

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal representative's name: _____

Relationship to patient: _____

If the patient refuses to sign this form:

Please state reason why patient refused to sign this form: