La Grange Dental Associates, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign This Acknowledgement

I, (Print) Your Name: _____ have received a copy of this office's

Notice of Privacy Practices. Sign: _____

Date: _____

Please Check One of the Following

- **You may communicate with the following individuals relating to my medical or payment information.**

  Name: **_____**

  Relationship**: _____**

  Contact Info**: PHONE: _____ E-MAIL: _____**

- **Please do not discuss my medical or payment with the following individuals._____**

- **Please do not discuss my medical or payment information with anyone.**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- **Individual refused to sign**
- **Communications barriers prohibited the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other (Please Specify)**