Russell B. Fox, D.M.D., PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, ______________________________, have received a copy of

(Parent name if patient is not 18 yrs. Of age)

this office's Notice of Privacy Practices

Please Print Name (patient name) ________________________

SIGNATURE_______________________DATE______________

(parent signature if patient is 18 yrs of age)

____

__________________for office use only__________________

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

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (please specify)