Dental Clinic of Marshfield sc

CHART #_____

ACCOUNT #_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of
(Name of Patient)
Dental Clinic of Marshfield, S.C.'s Notice of Privacy Practices. This Notice describes how Dental Clinic of Marshfield, S.C. may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

_____
(Name of Dependent)

_____
(Name of Dependent)

_____
(Name of Dependent)

_____
(Name of Dependent)

_____
(Name of Dependent)

_____
(Name of Dependent)

_____
(Name of Dependent)

_____
(Name of Dependent)

_____
(Signature of Patient, or Personal Representative) (Date)

_____
Relationship to Patient(s)