ORAL & MAXILLOFACIAL SURGEONS, PC

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient Information:

Name: _____

Address: _____

Telephone: _____ **E-mail** _____

Social Security Number: _____

Acknowledgement of Receipt of Privacy Practices Notice:

I, _____ **,** acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____

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

Personal Representative's Name: _____

Relationship to Individual: _____

Other Information: _____

_____

_____

_____

_____

Signature:

I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____