ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

I understand that I can make any changes or revocations by contacting the office at the following address:

Pure Dental
5321 East Mockingbird Lane, Space 210, Dallas, TX 75206
Phone: 214-824-7873

PATIENT NAME: _____

PERSON SIGNING THIS FORM _____

RELATIONSHIP TO PATIENT _____

SIGNATURE _____ DATE _____

Please Print Name _____