ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided **Perfect Smiles Family Dentistry** Notice of Privacy Practices ("Notice"):

- It tells me how Perfect Smiles Family Dentistry will use my health information for the purposes of my treatment, payment for my treatment, and Perfect Smiles Family Dentistry's health care operations.
- The Notice also explains in more detail how Perfect Smiles Family Dentistry may use and share my health information for other than treatment, payment, and health care operations.
- Perfect Smiles Family Dentistry will also use and share my health information as required/permitted by law.

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Signature of Patient or Legal Representative

_____

Print Patient Name

_____

If signed by legal representative, state relationship to patient

_____

Date