

# Erickson Pediatric Dentistry & Orthodontics PC

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I hereby signify have received a copy of, or been given access to a readable copy of, this office's Notice of Privacy Practices.

\_\_\_\_\_  
(Please Print Patient's Name)

\_\_\_\_\_  
(Signature of Patient or Guardian)

\_\_\_\_\_  
(Date)

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### For Office Use Only

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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
  - Communications barriers prohibited obtaining the acknowledgement
  - An emergency situation prevented us from obtaining acknowledgement
  - Other (Please Specify)
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