

**ANGELA M ENRIQUEZ, DDS
CIBOLO DENTAL CENTER, PLLC
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

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Patient Name:

(Last, First Middle) _____

Date of Birth _____

- I hereby acknowledge that I was given a copy of the Notice of Privacy Practices that describes how my private health information is used and disclosed.

- I hereby acknowledge that I was offered a copy of the Notice of Privacy Practices that describes how my private health information is used and disclosed. I have declined to receive this document but will sign the acknowledgement.

Signature of individual or representative:

Date _____

- If representative, relationship to patient (parent, guardian, etc)

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ADMINISTRATIVE USE ONLY

- If patient declines to sign, staff should document below:

I provided the Notice of Privacy Practices to the patient or his/her Legally Authorized Representative on this date.

Signature _____ Date _____