
Cooke, Richardson & Overstreet, D.D.S. P.C.

***ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES***

*****You may refuse to sign this acknowledgement*****

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

Please Print Patient's Name

Signature Patient/Parent or Guardian

Date

I give permission for Dr. Cooke, Richardson and Overstreet's office to give my personal information to the following people:

_____ *Relationship:* _____
_____ *Relationship:* _____
_____ *Relationship:* _____

For Office Use Only

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*
- _____ *Communication barriers prohibited obtaining the acknowledgement*
- _____ *An emergency situation prevented us from obtaining acknowledgement*
- _____ *Other (please specify)*