

James B. Polley D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE:

I, _____, acknowledge that I have received a
(PRINT FULL NAME)

Notice of Privacy Practices from the above-named practice for the above named patient.

Signature _____ Dated: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative

Name: _____ Relationship: _____

If you would like your health information disclosed to a spouse or personal representative please note the person's name and relationship below:

Name: _____ Relationship: _____

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