ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Thomas Anderson, DDS Notice of Privacy Practices, detailing how my heath information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice.

I understand that I have the right to request restrictions concerning the use of my information. I request the follow restrictions:

1. _____

2. _____

3. _____

_____ _____

Patient Signature Date

If not signed by patient, please indicate relationship to patient.

_____ _____

RELATIONSHIP WITNESS BY

INTERNAL USE ONLY

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on: _____ _____

DATE TIME

BY: _____

NAME AND TITLE