

ISLAND SMILES DENTAL
8940 S. MARYLAND PKWY., SUITE #100
LAS VEGAS, NEVADA 89123
(702) 270-6501 PHONE
(702) 260-4249 FAX

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ **E-mail:** _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above named practice.

Signature: _____ **Date:** _____

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

Personal Representative's Name: _____

Relationship to patient: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form:

Describe the reason why the individual would not sign this form:

SIGNATURE.

I attest that the above information is correct.

Signature: _____ **Date** _____

Print Name: _____ **Title** _____

INCLUDE THIS ACKNOWLEDGEMENT OF RECEIPT IN THE INDIVIDUALS RECORDS

**ACKNOWLEDGEMENT OF RECEIPT OF
PRIVACY PRACTICES NOTICE**