JAMES R. ANDERSON, D.D.S.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You may Refuse To Sign This Acknowledgment

I have read or have received a copy of this office's Notice of Privacy Practices. I may have a copy for my records upon request. I understand this may be revised at which time I am entitled to be informed.

_____

Patient Name Date

_____

Signature of patient

_____

Personal representative information to be shared with Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____Individual refused to sign
(Please Specify)

_____

You may contact Secretary of United States Department of Health and Human services with questions or concerns