



Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I am acknowledging that: I am either the patient or the patient's personal representative; I have received a copy of the "Notice of Privacy Practices" for Cherry Valley Smiles; and I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

Signature of patient or parent/legal guardian/legally responsible person

Date

Description of relationship to patient

Office Use Only

Cherry Valley Smiles attempted to obtain written acknowledgement of receipt of our Notices of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify below)

