ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

DRS. JOHNSON, SANFILIPPO & GOEBEL
643 ROUTE 184
GROTON, CT 06340
(860) 445-8569

NAME OF PATIENT: ________________________________

I hereby acknowledge that I received a copy of this dental practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed:_______________________________________ Date__________

Print Name:____________________________________ Telephone__________

If not signed by the patient, please indicate your relationship to the patient:_________________

For office Use Only:

Signed form received by: ____

Acknowledgment refused:
Efforts to obtain:____________________________________

Reason for refusal:__________________________________