The Atlanta Center for Restorative Dentistry

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Atlanta, GA 30342

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Acknowledgement of Receipt of Privacy Practices Notice

SECTION A: The Patient

Name:							
Address:		**City:**		**State:**		**Zip:**	
Home Phone(s):							
Work Phone(s):							
Cell Phone(s):							
Email(s):							

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice

By signing and returning this form, I acknowledge that I have received a Notice of Privacy Practices from The Atlanta Center for Restorative Dentistry.

Signature:		**Date:**	

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

Personal Representative's Name:	
Relationship to Individual:	

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:**	
Social Security Number:			