ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Thoroughbred Dental Arts, LLC's Notice of Privacy Practices, which has an effective date of 09/22/2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

We protect our Patients privacy according to HIPPA guidelines. If there are any additional person(s) you would like your health information to be shared with please list them below.

Name_____Relationship_____Date_____

Name_____Relationship_____Date_____

Name_____Relationship_____Date_____

Name_____Relationship_____Date_____

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____

Signature of Patient or Patient Representative Date

Print Name

_____

Relationship to Patient (If not signed by Patient)