

CEDAR CREEK DENTAL ASSOCIATES, LTD.

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this  
office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**I Allow You To Give Clinical And Financial Information To Or Answer Questions From: (Check all that apply)**

- Spouse \_\_\_\_\_
- Parent(s) \_\_\_\_\_
- Child \_\_\_\_\_
- Other (Specify) \_\_\_\_\_

\_\_\_\_\_  
**Patient Signature / Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Birth Date**