NOLL DENTISTRY, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: _____

I, _____, have received or read a copy of Cynthia R. Noll's Notice of Privacy Practices.

_____ **_____**
Please Print Name **Patient Signature**

If completed by a patient's personal representative or parent, please print and sign your name below.

_____ **_____**
Please print name **Personal Representative's signature**

I authorize the disclosure of my health and financial information to the following family member or personal representatives:

_____

_____ **_____**
Name **Relationship**

_____ **_____**
Name **Relationship**

_____ **_____**
Name **Relationship**

_____ **_____**
Print Patient's or Representative's name **Patient or Representative's Signature**