Smile Place
a pediatric dentist

## PARENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of my provider's Notice of Privacy Practices, containing information about how my protected health information may be used and/or disclosed.

Patient Name (printed) _____

Patient Signature, if over 18 yo _____

If patient is under the age of 18 years-old, name of personal representative. This is generally the parent or legal guardian. **

Print Name _____

Signature _____

Date _____

** By signing this form, you certify that you have legal authority to make healthcare decisions about the minor patient listed above.

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### NOTICE REGARDING OTHER INDIVIDUALS INVOLVED IN THE PATIENT'S CARE

As the personal representative of the above named patient, I am identifying the following individual(s) who may accompany the above named patient to clinic visits, who are involved in the patient's care and treatment and who may receive information regarding the individual's involvement in the patient's care and treatment.

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Personal Representative

_____ _____

Signature Date