**HIPAA FORM**

The Responsible Party:

Name: ____________________________________________________

Address: __________________________________________________

Phone :(                    )___________________________________          SS#:__________________________________

This acknowledgment of receipt is to include the following family members:

_______________________________________________          _______________________________________________

_______________________________________________          _______________________________________________

_______________________________________________          _______________________________________________

I, ______________________________________________, acknowledge that I have received a copy of the notice of privacy practice from the below named practice.

_______________________________________________          ________________________

Patient/Guardian Signature                                                        Date

**Brett R Warn DDS, 5103 NW Cache Road Lawton, OK 73505**

**Office (580) 248-4224**

**Fax (580) 248-4299**