

**STACY KIRNER FELIX DMD, INC.**

***Acknowledgement of Receipt of Notice of Privacy Practices***

I acknowledge that I have been provided a copy of Stacy Felix DMD, Inc's. Notice of Privacy practices, which has an effective date of 8/1/2014, 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.

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

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

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

I have received a copy of the Dental Materials Fact Sheet

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