



## **Acknowledgment of Receipt of Notice of Privacy Practices**

I acknowledge that I have been provided a copy of Newport Beach Dentistry's Notice of Privacy Practices, which has an effective date of 2/16/15, and which describes how my health information may be used and disclosed.

I understand that Newport Beach Dentistry has the right to change the Notice of Privacy Practices at any time. I will be provided a copy of the updated version and may also contact the Policy Officer at any time to request a current Notice of Privacy Practices.

By signing below, I acknowledge that I have read the Notice of Privacy Practices:

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**Signature of Patient or Patient's Representative**

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**Date**

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**Print Name**

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**Relationship to Patient (if not signed by the patient)**

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**Name(s) of Family Member(s) or Representative(s) that  
Newport Beach Dentistry can release information to**