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Acknowledgement of Receipt of Notice of Privacy Practices

This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

PATIENT(S) NAME: \_\_\_\_\_

I, \_\_\_\_\_ have reviewed the Notice of Privacy Practices  
(Parent/legal guardian/foster parent)

**from the office of Amy Phillips, D.M.D., L.L.C. and give my permission to allow disclosure of treatment, dental health and financial matters to the following person(s) appointed below:**

Name of Person: \_\_\_\_\_

Relationship to person named: \_\_\_\_\_

Name of Person: \_\_\_\_\_

Relationship to person named: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Parent, Legal Guardian or Foster parent)

Date: \_\_\_\_\_