



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

I acknowledge that I have received a copy of the **Notice of Privacy Practices** from King Orthodontics. I understand that this notice describes how my (or my child's) health information may be used and disclosed, and how I can access this information.

I understand that King Orthodontics reserves the right to change its Notice of Privacy Practices at any time and that a copy of the current notice will be available upon request and/or posted in the office.

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**Patient Information**

**Patient Name:** \_\_\_\_\_

**Parent/Guardian Information (if patient is a minor)**

**Parent/Guardian Name (Print):** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Signature**

I acknowledge receipt of the Notice of Privacy Practices.

**Signature of Patient or Parent/Guardian:**

\_\_\_\_\_

**Date Signed:** \_\_\_\_\_

\_\_\_\_\_

**Office Use Only**

**Witness Signature:** \_\_\_\_\_

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