

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's
(Print Parent or Legal Guardian's Name)

Notice of Privacy Practices.

{Please Print Name of **Patient(s)**}

{Signature}

{Date}

I specifically request that the following individuals be granted access to medical information about myself (or if a minor, my child) without restriction:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Consent for Photography/Social Media

- I give my permission for the office of Shari C. Kohn, DDS PA (t/a Dentistry for Kids) to use my/my child's photograph for the purpose of demonstration, teaching, or sharing on Social Media//Website.
- I would prefer to opt-out of photographs of myself or my child.