

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

Please list the names, (first and last) of all minor children covered under this Notice.

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Date of Birth*

I have been given a copy of the Dentistry for Kids / Hunt Valley Orthodontics *Notice of Privacy Practices* ("Notice"), which describes how the Practice uses and shares health information regarding the above-named minor children. I understand that the Practice has the right to change the *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Officer.

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

\_\_\_\_\_  
*Signature of Patient/Parent or Personal Representative*

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

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

\_\_\_\_\_  
*Personal Representative's Title (e.g., Guardian, Health Care Power of Attorney)*

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**For Facility Use Only: Complete this section if you are unable to obtain a signature.**

If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

\_\_\_\_\_  
\_\_\_\_\_

Completed by:

\_\_\_\_\_  
*Signature of Practice Representative*

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

\_\_\_\_\_  
*Print Name and Title*