Atlee Family & Cosmetic Dentistry

A division of Central Virginia Dental Clinic

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to Sign this Acknowledgement & Authorization

I, _____, have received a copy of this office's Notice of Privacy Practices and I allow Dr. Alice Xiang and staff to discuss my dental record and financial account with the authorized person(s) listed below. This authorization can be revoked at any time with written notice.

1. _____ _____
   Name Relationship to Patient

2. _____ _____
   Name Relationship to Patient

3. _____ _____
   Name Relationship to Patient

4. _____ _____
   Name Relationship to Patient

5. _____ _____
   Name Relationship to Patient

_____ _____
Signature of Patient Date

_____
Printed name of Patient

OFFICE USE ONLY

If patient refused to sign, indicate reason why: _____