ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Salmon Creek Oral Surgery & Periodontics reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the **“Notice of Privacy Practices”** for **Salmon Creek Oral Surgery & Periodontics.**

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Name of Patient (Print or Type)

____

Signature of Patient

____

Date

____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

____

Relationship of Patient Representative to Patient