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**3720 NW 43rd St, Suite 102**

**Gainesville, FL 32606**

**Ada Parra, DDS, MS**

**Justin Craighead, DMD, MS**

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

Notice to patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I received a copy of this office’s Notice of Privacy Practices.

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*Please print your name here*

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*Signature*

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

*Date*

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but could not obtain because:

* The patient refused to sign.
* Due to an emergency situation it was not possible to obtain an acknowledgement.
* We weren’t able to communicate with the patient.
* Other (Please provide specific details)

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*Employee Signature Date*