

AZLE DENTAL CARE
A. BROOKE PORTER, D.D.S.
912 Boyd Road
Azle, Texas 76020
(817) 444-1763

SECTION A: The Patient

Name: _____

Address: _____

Telephone: _____ E-Mail: _____

Patient Number: _____ Social Security #: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: I gave a copy of our Privacy Practices to the patient/patient's representative. _____

Describe the reason why the individual would not sign this form: _____

SIGNATURE

I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: Melisa Hartman

Title: Office Manager

**ACKNOWLEDGEMENT OF RECEIPT OF
PRIVACY PRACTICES NOTICE**

