S.A.ELAHWAL DENTISTRY P.C
481 83rd Street, Brooklyn N.Y, 11209
Tel: (718)748-1122
Fax: (718)748-9400

Section A: The Patient

Name: _____
Last First Initial

Address: _____

Phone Number: 1(___) _____ 1(___) _____

E-mail: _____@_____.com

Patient's Number: _____

Social Security Number: _____

Section B: Acknowledgement of receipt of privacy notice:

I, _____, acknowledge that I have received a notice of privacy practices from the above named practice.

Signature:_____ Date:_____

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

Personal representative's name: _____

Relationship to representative: _____

Section C: Good faith effort to obtain acknowledgement of receipt.

Describe your good faith to obtain the individual's signature on this form:

_____

_____

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

_____

Signature: _____

I attest that the above information is correct:

Signature:_____ Date: _____

Print name: _____ Title: _____

Include this acknowledgment of receipt in the individual's record