

Louis Saliba D.M.D.
15561 W High St. Suite 7
Middlefield, OH 44062

Section A: The Patient

Name: _____
Address: _____
Telephone: _____ E-mail: _____

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: _____

Signature:

I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.