ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been informed of the September 2013 Revision

I _____have received/read a copy of this Office's Notice of Privacy Practices.

I give the following permission to AZ Sleep and Snoring Center:

I give this office permission to speak with:_____ regarding my account billing, dental health and/or treatment needs. (Excludes medical providers)

I gives this office permission to correspond via text and email:

_____ _____

Cell Number Email Address

_____

Signature of Patient

_____ _____

Printed name of Patient Date

We attempted to obtain written acknowledgement of receipt of our Notice Privacy Practice, but acknowledgement could not be obtained because:_____

_____