

Dr. R. Danford Doss, Inc.
Dr. Elizabeth A. Gold, D.D.S., M.S.

ACKNOWLEDGEMENT OF RECEIPT
Of Notice Of Privacy Practices

I have received a copy of this offices Notice Of Privacy Practices. If I am a minor unaccompanied by a parent or guardian, I will accept this Notice and provide it to my parent or guardian.

Please Print Name

Signature

Date

The patient was offered a copy of the Notice Of Privacy Practices. An attempt was made to obtain a signature on this Acknowledgement of Receipt for the notice. It could not be obtained because

- Individual refused to sign
- Parent stated that a copy was received previously prior to treatment of sibling
- Communications or language barrier
- Emergency situation prevented obtaining acknowledgement
- Other (Specify Below)

Received by _____ Date _____

The individuals designated below are hereby authorized to access or receive information about my child's healthcare from this practice or to participate in treatment related decisions. Anyone not specifically named below is prohibited.

_____	_____
_____	_____
_____	_____
_____	_____

