Patricia Mahoney DMD

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Cell: _____ email: _____

Do you give our office permission to discuss your medical/dental information with friends/family

Yes No

**If yes, please provide their name & phone number below

Name: _____ Relationship:_____
Phone (day): _____ (Evening):_____

Name: _____ Relationship:_____
Phone (day): _____ (Evening):_____

Name: _____ Relationship:_____
Phone (day): _____ (Evening):_____

May we leave personal medical/dental information on your answering machine?

Yes No

Thank you for choosing Dr. Patricia Mahoney for your dental needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____ _____
Signature of Patient (or Legal Representative) **Date**

_____ _____
Signature of Staff Member **Date**

Comments: