Pediatric Dentistry + Orthodontics

CONCORD & MARLBORO

Acknowledgement of Privacy Practices

You have the right to refuse to sign this acknowledgement.

I, _____ (Guardian Name), acknowledge that I have been informed of the privacy practices regarding the handling of patient information. A copy of the written policy is available for review upon request by mail, fax, or email.

Patient Name: _____
Guardian Signature: _____
Date: _____

For Office Use Only

Efforts were made to obtain a signed acknowledgement of our Privacy Practices, but the acknowledgement could not be obtained for the following reason(s):
_____ Individual refused to sign
_____ Communication barriers prevented obtaining acknowledgement
_____ Emergency circumstances prevented obtaining acknowledgement
_____ Other: _____

Date: _____ Staff Initials: _____