SMILE INNOVATIONS

HIPAA- Acknowledgement of Receipt

Notice of Privacy Practices

Printed Patient Name: ____

Patient Date of Birth: ______________________

I hereby acknowledge that I have read/received the HIPAA Notice of Privacy Practice Acts document.

Signature of patient/legal guardian: ______________________ Date: _______________

Printed name of patient/legal guardian: _________________________

Please list any person by name/relationship, that you allow us to share your private information with:

1.____

2.____

3.____

4____

IF YOU WOULD LIKE A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICE DOCUMENT PLEASE REQUEST FOR THIS AT THE FRONT DESK.