



**Avalon Dental
James D. Grant DMD
672 E Wythe Creek Court, Suite 101
Kuna, ID 83634**

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient: _____

I _____, acknowledge that I have read and understand the Notice of Privacy Practices from Avalon Dental.

Signature of Patient or Guardian

Today's Date

If a personal representative (other than a parent or guardian) signs this authorization on behalf of the individual, complete the following:

Personal representatives name

Relationship to individual

For Office Use Only

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

- Individual refused to sign
- Communications barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)