SOUTH GASTON
PEDIATRIC DENTISTRY

Acknowledgement of Privacy Practices

Patient First Name	Patient Last Name	Birthday mm/dd/yyyy

I certify I have received a copy of South Gaston Pediatric Dentistry's Notice of Privacy Practices

Signature of Parent/Guardian_____ Date _____

Printed name of Parent/Guardian: _____

I give full permission for the below listed, to have complete access to patient listed above. This includes, but is not limited to, chart details, x-rays, and dental restoration needed. I also give full authority to make any decisions necessary for any treatment planned in relation to the patient's dental needs from South Gaston Pediatric Dentistry.

Name/Relationship to patient: _____
Name/Relationship to patient: _____

Signature of Parent/Guardian_____ Date _____
Printed name of Parent/Guardian: _____

Staff Will Complete This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain a written Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason(s):

- □ Parent/Patient/Guardian refused to sign
- □ Emergency situation kept us from obtaining signature
- □ Language barrier kept us from obtaining signature
- □ Other:

Signature of Company Representative: _____ Date _____

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