

Peter D. Kiryakos, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

For Patient:

I have been offered a copy of this office's Notice of Privacy Practices.
I also give my consent to share my/the patient's health related information with the following people (circle all that apply):

Mother / Father / Son(s) _____ / Daughter(s)
_____/ _____
Grandmother _____ / Grandfather _____ / Other _____

If the patient is a minor: By signing below, I attest that I have legal custody of the above named patient.

Please Print Name

Signature

Date

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 barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

