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ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

IN ACCORDANCE WITH HIPAA REQUIREMENTS

I, ____,

Patient, Parent, Guardian

have received a copy of

DELMARVA DENTAL SERVICES'

"NOTICE" OF PRIVACY PRACTICES

FOR

PLEASE PRINT PATIENT'S NAME: ______________________________________

IF NOT ALREADY LISTED ABOVE

SIGNATURE: ______________________________ DATE: ____________________

(FILE IN CHART)