
KEVIN R. AUSTIN D.D.S., M.S., P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PLEASE PRINT PATIENT'S NAME

I, _____, HAVE RECEIVED A
(Parent or Guardian)
COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

SIGNATURE

DATE

_____ I agree to allow my photograph to be displayed in the waiting room. I agree to allow my name to be used in the office newsletter if I am a contest winner.

_____ I do not want my picture displayed in the waiting room.

_____ I do not want my name in the office newsletter.