ACKNOWLEDGEMENT OF
RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I,_____, hereby acknowledge that I have received a copy of the Privacy Practices of DR. JASON ANNAN, DDS

_____ I give permission for appointment information to be left on my answering machine, or voice mail.

_____ Numbers I do not wish messages to be left on are:

_____

_____ I give permission for my dental information to be given to my spouse/ significant other, other dental providers and/or my insurance company.

Date:_____ _____
Signature of Patient or Patient's Representative

_____
Description of Representative's Authority
Parent of Minor
Guardian