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## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE

Patient

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_

I, \_\_\_\_\_ acknowledge that I have received a notice of  
Privacy Practices from the above named practice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a personal representative signs this authorization on behalf of the individual,  
please complete the following:

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For office use only – Do not write below this line

Good faith effort to obtain Acknowledgement of receipt.

Describe your good faith effort to obtain the individual's signature on this form: \_\_\_\_\_  
\_\_\_\_\_

Describe the reason why the individual would not sign this form: \_\_\_\_\_  
\_\_\_\_\_

Signature

I attest that the above information is correct.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_