

Randolph R. Resnik, D.M.D., M.D.S.

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

*** You may refuse to sign this acknowledgement ***

I, _____, have read a copy of this office's Notice of Privacy Practices and will be furnished with a copy upon request.

X _____
Please Print Name

X _____
Signature

X _____
Date

For Office Use Only

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgements
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)
