

**NORTH PENN DENTAL ARTS**  
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**Privacy Practices Statement:  
Acknowledgement of Receipt**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

I, \_\_\_\_\_, acknowledge that I have read and received a copy of the Privacy Statement from this office.

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Personal Representative Signature Relationship to Patient

I authorize the following individual(s) access to any dental information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_