Laura B. Glicksman, MS, DMD, PC

# Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

## You are entitled to a copy of this office's Notice of Privacy Practices

Print Patient Name:_____________________________________________________

Signature:__________________________________________________________
Patient or Parent/Guardian/Personal Representative if patient is a minor

Relationship to Patient:__________________________________________________

**For Office Use Only**

____________________________________________________________________

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

____________________________________________________________________

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