

Avalon Dental
James D. Grant DMD
672 E. Wythe Creek Court, Suite 101
Kuna, ID 83634

Acknowledgment of Receipt of Notice of Privacy Practices

Name of Patient: _____

I _____, acknowledge that I have read and understand
the Notice of Privacy Practices from Avalon Dental.

Signature of Patient or Guardian

Today's Date

If a personal representative (other than a parent or guardian) signs this authorization on
behalf of the individual, complete the following:

Personal representative's name

Relationship to individual

For Office Use Only

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

- ___ Individual refused to sign
- ___ Communications barrier prohibited obtaining the acknowledgment
- ___ An emergency situation prevented us from obtaining acknowledgment
- ___ Other (please specify)

