



I acknowledge that Mailloux Dentistry's "Notice of Privacy Practices" has been made available to me. I understand I have the right to review Mailloux Dentistry's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations at Mailloux Dentistry.

The Notice of Privacy Practices is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Mailloux Dentistry's duties with respect to my protected health information.

Mailloux Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent in the mail or by asking for one at the time of my next appointment.

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*Signature of Patient or Personal Representative*

*Date*

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*Description of Personal Representative's Authority (Parent/Legal Guardian)*

*Date*

Please list below the names of person(s) authorized to gain access to patient account information:

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For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barrier
- Emergency situation