

**ALLEN F. AVRUTIN, D.D.S., F.A.G.D.  
JERRY L. STATMAN, D.M.D., F.A.G.D.**

**THE PATIENT (please print)**

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

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

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

I, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient, Parent or Guardian

Relationship to Patient \_\_\_\_\_

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**Good Faith Effort to Obtain Acknowledgement of Receipt.**

Describe your good faith effort to obtain the individual's signature of this form: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe the reason why the individual would not sign this form: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Include this acknowledgement of receipt in the individual's records.*

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE**