

**SOUTHMOOR PEDIATRIC DENTISTRY
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges the he or she received a copy of the Southmoor Pediatric Dentistry Notice of Privacy Policies on the date indicated below.

Signature: _____ Date: _____

Patient: _____

Information about Agent (attach appropriate documentation):

Agent *[Handwritten Signature]*
Title: *Practice Manager*