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FAMILY DENTISTRY

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a
copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name or

Legal Guardian: _____

Relationship to Patient: _____

For Office Use Only

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

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify)
