

RICHARD D. SALZMANN, D.M.D.
DIPLOMATE AMERICAN BOARD OF PERIODONTOLOGY
PRACTICE LIMITED TO PERIODONTICS
AND ORAL IMPLANTOLOGY

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Richard D. Salzmnn, D.M.D., P.A., this ___ day of _____, 20___. A copy of this signed, dated Acknowledgement shall be as effective as the original.

Please print your name

Please sign your name

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority _____.

Thank you and if you have any questions about this form or the attached Notice, please contact our Privacy Official, Martha, at 954-435-1102.

Office Use Only

As Privacy Official, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

- It was emergency treatment _____
- I could not communicate with the patient _____
- The patient refused to sign _____
- The patient was unable to sign _____
- because (please describe) _____

Signature of privacy official

Signature of patient refusal to sign acknowledgment

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(954)435-1102