ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

JAMES B. PHILLIPS, MS, DDS, PA

I have received a copy of James B. Phillips, MS, DDS, PA, Notice of Privacy Practices which describes how my health information is used and shared. I understand that James B. Phillips, MS, DDS, PA, has the right to change this notice at any time. I may obtain a current copy by contacting the Facility Privacy Officer, or by visiting the Facility website at www.drjamesbphillips.com.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____

Signature of Patient Date

_____

Printed Name

_____

Personal Representative and Title (e.g. Guardian, Executor of Estate, Power of Attorney)

FOR FACILTITY USE ONLY:

If the patient or patient's representative is unwilling or unable to sign this Acknowledgement, state the reason and describe the steps taken to obtain the signature.

_____

_____

_____

_____ _____

Facility Representative Signature Date

_____

Printed Name