

**NOTICE OF PRIVACY PRACTICES FOR
KATHERINE M. HAKES, DDS —ACKNOWLEDGEMENT**

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

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

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

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An Emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify) _____

This form will be retained in your medical record.

Last Update: ___/___/___