Stanley J. Boyd, DMD

77 W. 15th Street
New York, NY 10011
(212)206-0513
Fax (212)206-1232

"Creating healthy, beautiful smiles....for a lifetime."

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 Stanley J. Boyd, DMD. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____
Please print your name

_____
Please sign your name

_____
Date of your signature

If you are the legal representative of the patient, please print the patients' 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 officer, at:

Privacy Officer for Stanley J. Boyd, DMD
77 W. 15th Street
New York, NY 10011
(212) 206-0513
Fax (212) 206-1232

Office Use Only

As privacy officer, 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	____
Other (please describe)	____

_____
Signature of privacy officer