SOUTHMOOR PEDIATRIC DENTISTRY

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient of legally authorized representative ("Agent") of Patient acknowledges that he or she received a copy of the Southmoor Pediatric Dentistry Notice of Privacy Policies and Photography release form on the date indicated below.

Signature:_____ Date:_____

Patient:_____ Date:_____

Information about Agent (Attach appropriate documentation):

Agent: _____

Title: _____