

**PENINSULA**  
Periodontics & Orthodontics



***NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT***

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Name of parent or legal guardian if patient is a minor, personal representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Describe your role in regard to the patient and/or the authority by which the person is signing for the patient: \_\_\_\_\_  
\_\_\_\_\_