ENDODONTIC
ASSOCIATES
Root Canal Therapy & Microsurgery

***Patient Acknowledgment of Notice of HIPAA Privacy Practice***

Patient name:____________________________________________________________

Thank you very much for taking time to review how we are carefully using your health information. We would appreciate acknowledging your receipt of our policy by signing this form to be kept with your records.

If you have any questions, please call our office at 303-796-7676.

Patient signature:
_____________________________________________________________

Legal Guardian if patient is a minor: ____________________________________________

Date: _____________________