ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

THIS UNDERSIGNED ACKNOWLEDGES THE CURRENTLY
EFFECTIVE NOTICE OF PRIVACY PRACTICES FOR
DR. ALEX DESMAN DMD MS

DATE:_____

A COPY OF THIS SIGNED, DATED ACKNOWLEDGMENT SHALL
BE EFFECTIVE AS THE ORIGINAL

PLEASE PRINT PATIENT NAME_____

PLEASE SIGN YOUR NAME _____

IF YOU ARE THE LEGAL REPRESENTATIVE OF THE PATIENT,
PLEASE PRINT YOUR NAME IN DESCRIBED AUTHORITY

MOTHER _____

FATHER _____

LEGAL GUARDIAN _____