

Alicia Matayoshi DMD, PA

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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 **Alicia Matayoshi DMD, P.A.** A copy of this signed, dated Acknowledgement shall be as effective as the original.

Please print your name

Date

Please sign your name

Date

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: 904-854-2300.

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with patient _____

The patient refused to sign _____

The patient was unable to sign because _____.

Other (please describe) _____.

Signature of privacy officer