



DR. ELLEN IM
PEDIATRIC DENTISTRY
& ORTHODONTICS

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE
You May Refuse to Sign This Acknowledgement

The undersigned acknowledges receipt of a copy of the current effective Notice of Privacy Practice for Dr. Ellen Im Pediatric Dentistry. A copy of this signed, dated Acknowledgement shall be as effective as the original.

Please print your name

Please sign your name

Date of your signature

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority

If you have any questions about this form or attached Notice, please contact our privacy officer at:

Dr. Ellen Im Pediatric Dentistry
Attn: Privacy Officer
13422 Pomerado Road, Suite 201
Poway, CA 92064

OFFICE USE ONLY

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

- It was emergency treatment _____
- I could not communicate with the patient _____
- The patient refused to sign _____
- The patient was unable to sign because _____
- Other (please describe) _____

Signature of privacy officer