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PEDIATRIC DENTAL ASSOCIATES, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I have reviewed a copy of Pediatric Dental Associates, P.C. Notice of Privacy Practices.

Please Sign Name: _____

Please Print Name: _____

Date: _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Name of Child/Children:	Relationship to Individual Signing Acknowledgement:
_____	_____
_____	_____
_____	_____
_____	_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Consent for Use and Disclosure of Health Information, but were not able to obtain because:

- _____ Individual refused to sign
 - _____ Communication barriers prohibited obtaining the acknowledgement/consent
 - _____ An emergency situation prevented us from obtaining acknowledgement/consent
 - _____ Other (please specify)
- _____
- _____
- _____

Address and Phone of Doctor _____