



**The Dental Group, P.C.**

DENTISTRY WHEN YOU NEED IT  
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**Acknowledgement of Receipt of  
Notice of Privacy Practices**

*\*You May Refuse to Sign This Acknowledgement\**

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Patient Name \_\_\_\_\_  
*(Please print)*

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature of Patient or Responsible Party \_\_\_\_\_

Relationship to Patient (if not signed by patient) \_\_\_\_\_

Date \_\_\_\_\_

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**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

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

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