HIPAA Notice of Privacy Practices

Acknowledgement of Receipt

Loudoun Dental Associates, 24565 Dulles Landing Drive, Suite 190, Dulles, VA 20166

(703) 542-7600

I hereby acknowledge that I have read and received a copy of the attached dental practice's **HIPAA Notice of Privacy Practices of Loudoun Dental Associates.**

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- □ Parent or guardian of minor patient
- □ Guardian or conservator of an incompetent patient
- □ Beneficiary or personal representative of deceased patient

Name of Patient:

_____

_____Do not write below this line_____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused: _____

Efforts to obtain:

_____

_____

Reason for refusal:

_____

_____

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Dulles, VA 20166 (703) 542-7600