Scott A. Welch DDS PA
COSMETIC & FAMILY DENTISTRY

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Scott Welch, DDS Notice of Privacy Practices, detailing how my heath information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice.

I understand that I have the right to request restrictions concerning the use of my information. I request the follow restrictions:

_____

_____

_____

_____

With whom may we discuss your treatment:

_____

With whom may we discuss your payment:

_____

Patient Signature: _____ Date: ____ / ____ / ____

If not signed by patient, please indicate relationship to patient.

Relationship: _____ Witness By: _____

Internal Use Only

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Date: ____ / ____ / ____ Time: _____

By: _____
(Name and Title)

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