

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Dr. Laura Comeau, DDS Notice of Privacy Practices, which has an effective date of September 22, 2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

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**Signature of Patient or Patient's Representative**

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**Date**

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**Print Name**

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**Relationship to Patient (If not signed by the Patient)**