



**Scott F. Bobbitt, DMD, MAGD**

**Acknowledgement of Receipt of  
Notice of Privacy Practices**

I acknowledge the opportunity to review **Scott F Bobbitt, DMD, PA Notice of Privacy Practices**. I understand I may request a copy of the practice's Notice of Privacy Practices should I desire.

**Patient's Printed Name** \_\_\_\_\_

**Signature of Patient or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

Print Name of Guardian/Personal Representative \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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

**For Office Use Only**

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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