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### Acknowledgement of Receipt of Notice of Privacy Practices

We are required by the United States Government to provide each patient with this dental practice's Notice of Privacy Practices. The notice describes the safeguarding of your protected health information.

You have the right to choose whether or not you would like to receive a copy of the Notice of Privacy Practices. Simply make your selection below.

- I wish to receive a copy of the Notice of Privacy Practices at this time.
- I do not wish to receive a copy of the Notice of Privacy Practices at this time. I understand I may request a copy at any time.

I acknowledge that a copy of the current notice is posted in the reception area.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

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: \_\_\_\_\_