DiChristofano & DiChristofano
QUALITY DENTISTRY, COMPASSIONATE CARE

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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I acknowledge that I have received a copy of DiChristofano & DiChristofano Dental Care Privacy Practices.

Relationship to the patient:

☐ Self

☐ Parent

☐ Guardian

Signature _____ Date _____