



**SPARKS**  
FAMILY ORTHODONTICS  
*Laugh Grow Smile*

**HIPAA – ACKNOWLEDGEMENT OF RECEIPT  
Notice of Privacy Practices**

Printed Patient Name: \_\_\_\_\_

Patient Birthdate: \_\_\_\_\_

At Sparks Family Orthodontics we are required by law to maintain the privacy of our patients and to provide individuals with Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please ask to speak with the HIPAA official in our office.

I hereby acknowledge that I may request a copy of the HIPAA Notice of Privacy Practice document.

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of responsible party

\_\_\_\_\_  
Relationship to patient