H. Ivan Orup, Jr., DMD, MMSc
Specialist in Orthodontics and Dentofacial Orthopedics

Acknowledgement of Notice of Privacy Practices

I _____ acknowledge that I have read and understand the H. Ivan Orup Jr, DMD,
(Name of Patient)

MMSc Notice of Privacy Practices. This notice describes certain restriction on the use and disclosure of my healthcare information, rights that I may have regarding my protected healthcare information, and how H. Ivan Orup Jr, DMD, MMSc and his staff may use and disclose my protected healthcare information. By signing this agreement. I also give H. Ivan Orup Jr, DMD, MMSc and his staff permission to contact me by telephone (and to leave messages on an answering machine if necessary) to confirm and schedule any further appointments or conferences.

_____

(Signature of Patient or Personal Representative) (Date)

_____

(Relationship to Patient)