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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

\*You May Refuse to Sign This Acknowledgment\*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

Patient name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Guardian)

**TELEPHONE LIST:**

Please provide the name(s) of person(s) if any, to whom you would like our office to allow disclosures of personal information. Please also specify information that may be disclosed (i.e.: appointment information, payment information, prescriptions, results, etc. you may also indicate "All" if appropriate).

Name:	Relationship/Contact Phone #:	Allowed Disclosure(s):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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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