

Coastal Connecticut Dentistry
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign This Acknowledgement

I, _____, have received or reviewed a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

I give permission for Coastal Connecticut Dentistry to give the listed persons below of any personal health, insurance, account, and appointment information.

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- 1. Individual refused to sign*
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