



K STREET DENTAL AND ORTHODONTIC GROUP  
ACKNOWLEDGEMENT RECEIPT OF HIPPA FORM

This form is an individual's acknowledgment of awareness of the K Street Dental and Orthodontic Group Privacy Practice Notice.

I, \_\_\_\_\_, acknowledge that I have read a Privacy Practice Notice from K Street Dental and Orthodontic Group.

Signature: \_\_\_\_\_, Date: \_\_\_\_\_

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_