Karla J. Boyd, DDS
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918-272-0031

Acknowledgement of Receipt of Notice of Privacy Practices

I may refuse to sign this acknowledgement.

I have been offered and/or received a copy of Boyd Family Dentistry's Notice of Privacy Practices.

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party. I understand that I may request a copy of the privacy practices at any time.

_____ _____
Print Name Date of Birth

_____ _____
Signature Date

**This acknowledgement expires 3 years from initial signature dated above.

**This acknowledgement expires with a change in insurance coverage.