SARA KLASINSKI D.D.S.
1204 Fond du Lac Ave.
Kewaskum, WI 53040
262-626-2119

Acknowledgement of Receipt of Notice of Privacy Practices.

Name of Patient: _____

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above name.

Signature: _____ Date:_____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

******* Please return this acknowledgement form, signed, upon receipt *******