



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for:

Dr. Adam Diesburg, DDS
1927 NE Baker Street
McMinnville, OR 97128

Patient Name (Print): _____

Signature of Patient or Personal Representative:

Date: _____

If signed by Personal Representative, describe relationship to patient:

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of the Notice of Privacy Practices, but acknowledgment could not be obtained for the following reason:

- Patient refused to sign
- Patient unable to sign
- Emergency situation
- Other: _____