

**DAVID C. CIRCEO DDS, PC.**  
6113 Lakeside Avenue  
Richmond, Virginia 23228

Ph.: 804-262-9824  
Fax: 804-264-2834

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE**

I, \_\_\_\_\_, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

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

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

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

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