LARRY M. WOLFORD, DMD
DIPLOMATE OF THE AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY
BAYLOR UNIVERSITY MEDICAL CENTER, WORTH STREET TOWER
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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
FOR DR. LARRY M. WOLFORD – ORAL AND MAXILLOFACIAL SURGERY CLINIC

Patient Name: _____

Date of Birth: _____

I acknowledge that Larry M. Wolford, DMD - Oral and Maxillofacial Surgery provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient