



LARRY M. WOLFORD, DMD

DIPLOMATE OF THE AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY

BAYLOR UNIVERSITY MEDICAL CENTER, WORTH STREET TOWER
3409 WORTH STREET, SUITE 400, DALLAS, TX 75246

PHONE 214-828-9115

FAX 214-828-1714

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

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