

**Acknowledgment of Review of Notice of Privacy Practices**

I have reviewed a copy of the Notice of Privacy Practices for Dr. Bob Wrable, D.M.D.

Patient(s) Name (Print)	
Signature of Patient	
Date	
Signature of Patient Representative <small>(Required if the patient is a minor or an adult who is unable to sign this form.)</small>	
Relationship of the Patient Representative to Patient	