

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

Acknowledgement of Privacy Practices

Peter J. Pirmann, D.M.D., P.C.  
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Carbondale, IL 62901

Lynne Stewart  
Privacy Officer  
618-529-2212

I hereby acknowledge that I have seen and read a copy of Dr. Pirmann's Notice of Privacy Practices.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate

Relationship:

\_\_\_ Parent of guardian of minor patient

\_\_\_ Guardian or conservator of an incompetent patient

\_\_\_ Beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

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For Office Use Only:

\_\_\_ Signed form received by: \_\_\_\_\_

\_\_\_ Acknowledgement refused: \_\_\_\_\_

Efforts to obtain:

\_\_\_\_\_  
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