

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

**IMPLANT AND COSMETIC DENTISTRY OF MARYLAND
Dr. W. Michael Kenney, D.D.S., M.S.**

Acknowledgement of Receipt of Privacy Practices Notice

**I acknowledge that I have received a Notice of Privacy Practices from
Dr. Michael Kenney, D.D.S., M.S., P.A.**

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Individual: _____