DeAtley Dental Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have received a copy of this office's Notice of Privacy Practices

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Signature

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Date

I give permission to those listed below to have access to my medical information and to discuss matters relating to my care. I recognize that if I do not list anyone below, I am the only person who will have access to information regarding my medical information and care.

Name: ______________________________ Relationship: ________________

Name: ______________________________ Relationship: ________________

Name: ______________________________ Relationship: ________________

______________________________ ______________________________
Signature Date

A copy of the Notice of Privacy Practices is available upon request.