WHITE FAMILY DENTAL

People you know. People who care.

NOTICE OF PRIVACY PRACTICES

Patient Name:_____ Date:_____

I acknowledge that I have received the White Family Dental Notice of Privacy Practices that describes how my dental and medical information may be used or disclosed as required by federal law.

_____ _____

Signature of Patient, Parent or Guardian Print Name

Permission to Discuss Dental Information

The privacy of your dental and medical information is very important to us. If you wish us to discuss information about your medical condition to your family, friends, caregivers, or others, please indicate this by completing the information below.

I _____ (Patient or Guardian Name)

permit the discussion of (print patient's name) _____ healthcare information for the purpose of communicating results, findings, care decisions and billing/payment information to the following individuals:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

I understand that dental practice personnel will use their professional judgment to determine if the discussion is in my best interest if I am not present, incapacitated or in an emergency situation and that this authorization will remain in effect until revoked by me in writing.

_____ _____

Signature Date

****

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

___ Individual refused to sign

___Communication barriers prohibited obtaining acknowledgement

___An emergency situation prevented us from obtaining acknowledgement

___Other _____

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