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In accordance with a Federal Law on Patient Privacy, please read the following:

This statement is to advise you that our office has a privacy policy **(complete policy at your request)** in place to protect your dental information. In brief, our policy states that our office will keep your dental record confidential and will use it only for treatment, payment, and health care operations. Our policy identifies your right to access your records, request restrictions on who can see and be informed of your dental information.

Please provide our office with the best number or way of communication related to your dental benefits, financial agreements, treatment plans, and appointments.

Please check the following boxes:

☐ Cell phone ☐ Text Message ☐ Home Number ☐ Work Number

☐ Email _____

You have my permission to release my dental information to the following.
Please check boxes below, list name and phone number:

☐ Patient Only

Name and Phone Number

☐ Spouse / Domestic Partner _____

☐ Mother / Father _____

☐ Relative _____

☐ Friend _____

☐ Other _____

_____ _____

Patient's Signature / Responsible Party Date