

HIPPA FORM

Disclaimer

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence. It is my responsibility to inform this office of any changes in my personal or medical information. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____

Date _____

Privacy Practices

PERSONAL CARE DENTAL GROUP, LLC

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I, _____, understand that Personal Care Dental Group, LLC abides by the HIPAA Law and will protect the privacy of my personal information.

Please Print Name _____

Signature _____

Date _____

TO DISCLOSE PRIVATE INFORMATION TO PERSONS OTHER THAN THE PATIENT:

I, _____, give permission to Personal Care Dental Group to discuss my patient and account information with the following:

Name Relationship

Name Relationship

Signature _____

Date _____