NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
ALL SMILES DENTAL CARE
DR RHONDA GREEN

I have received on this visit or a previous one, the Notice of Privacy Practices that explains how the facility may use my information. The Notice of Privacy Practices is available at the office or online at www.allsmilesbydrgreen.com.
As explained in the Notice of Privacy Practices, the facility will only obtain my written authorization to release information about me if it is not permitted or required by law to disclose this information without authorization.

THIS DOCUMENT WILL REMAIN IN EFFECT FOR 12 MONTHS. I HAVE THE RIGHT TO MAKE CHANGES TO MY APPOINTMENT NOTIFICATIONS BY REQUESTING A NEW FORM WITH MY SIGNATURE

First Name MI Last Name Date of Birth

Signature of Patient / Parent or Legal Guardian Date

PATIENT OF RECORD DISCLOSURES

IN GENERAL, THE HIPPA PRIVACY RULE GIVES INDIVIDUAL THE RIGHT TO REQUEST RESTRICTION ON DISCLOSURE OF THEIR PROTECTED HEALTH INFORMATION (PHI). I GIVE CONSENT FOR ANY CONFIDENTIAL COMMUNICATIONS OR A COMMUNICATION OF PHI MAY BE MADE BY THE FOLLOWING MEANS

TELEPHONE # LEAVE MESSAGE WITH DETAILED INFORMATION Y N

WORK PHONE# LEAVE MESSGE WITH DETAILED INFORMATION Y N

WRITTEN COMMUNICATION: EMAIL TO

OTHER PERSONS AUTHORIZED TO ACCESS ACCOUNT:

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER