



ACKNOWLEDGEMENT OF PRIVACY PRACTICES

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer.

Signature Date

AUTHORIZATION TO SHARE HEALTH CARE INFORMATION
You may share the following health care information with:

Name: _____ **Relationship:** _____

Please check all that apply:

- All health care information on my dental record
- Other (appointments, test results, etc.) _____
- Insurance and billing information

This authorization ends:

- In 90 days from the date signed
- On (date): _____

Signature Date