NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see any copy of 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.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. A copy will be provided upon request.

This form will be retained in your medical records.

My signature below is my acknowledgement of the offices
Notice of Privacy Practices.

Patient or Legally Authorized Individual Signature Date/Time

Printed Name if Signed on Behalf of Patient Relationship

I,_____, authorize Family Dental Care of Bellevue to release information concerning the patient identified above, in accordance with state and federal laws to the following: