PREMIER DENTISTRY

COSMETIC and RESTORATIVE DENTISTRY

ASSURANCE OF PRIVACY

Please sign this form to acknowledge that you have read the Notice of Privacy Practices (HIPAA).

_____

Patient's Name (printed)

_____

_____/_____/_____

Patient or Responsible Party's Signature Date

If you have any questions, comments, or objections to the privacy policies on the attached letter, please ask to speak with our compliance officer. You have the right to review the entire privacy policy manual upon request.

Please provide the name, relationship, and telephone number of the proxy whom you wish to request information and/or speak on your behalf, if at all.

_____

_____

Proxy's Name (printed) Relationship

(_____) - _____ - _____

Proxy's Phone Number

☐ I do not wish to name a proxy at this time, but understand that I may, at any point in my relationship to Premier Dentistry, authorize a proxy to request and receive information on my behalf in the future.

_____

_____/_____/_____

Authorized Signature of Patient Date