

Acknowledgement of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Privacy Policy.
Name of Patient

Signature of Patient/Parent/Guardian Date

Authorization to Release/Discuss Information

I, _____, being of legal age, give Niceville Family Dental Center PL,
authorization to release and discuss my health and dental information with the person/persons listed below.

____ Parents Name(s) _____ Home# _____ Cell# _____ Work# _____

____ Spouse Name _____ Home# _____ Cell# _____ Work# _____

____ Other Name _____ Relationship to Patient _____

Home# _____ Cell# _____ Work# _____

This authorization will stay in effect unless I request that it be changed.

Signature _____ Date _____