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 Nathan Hall, DMD, 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_____Home#_____Cell#_____Work#_____

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

Signature_____Date_____