MINSTER DENTAL CARE

HIPAA ACKNOWLEDGEMENT

&

PERMISSION TO DISCUSS MEDICAL INFORMATION

PATIENT NAME: ______________________ DATE OF BIRTH ______________________

I have received and/or been offered a copy of the Minster Dental Notice Of Privacy Practices. I authorize the following list of people who may receive my Protected Health Information. I understand that I may revoke this authorization at any time by giving written notification to the office.

NAME	*DATE OF BIRTH*	*PHONE NUMBER*

RELATIONSHIP TO PATIENT: □ SPOUSE / □ CHILD / □ PARENT / □ LEGAL GUARDIAN / □ OTHER ______________

NAME	*DATE OF BIRTH*	*PHONE NUMBER*

RELATIONSHIP TO PATIENT: □ SPOUSE / □ CHILD / □ PARENT / □ LEGAL GUARDIAN / □ OTHER ______________

NAME	*DATE OF BIRTH*	*PHONE NUMBER*

RELATIONSHIP TO PATIENT: □ SPOUSE / □ CHILD / □ PARENT / □ LEGAL GUARDIAN / □ OTHER ______________

NAME	*DATE OF BIRTH*	*PHONE NUMBER*

RELATIONSHIP TO PATIENT: □ SPOUSE / □ CHILD / □ PARENT / □ LEGAL GUARDIAN / □ OTHER ______________

NAME	*DATE OF BIRTH*	*PHONE NUMBER*

RELATIONSHIP TO PATIENT: □ SPOUSE / □ CHILD / □ PARENT / □ LEGAL GUARDIAN / □ OTHER ______________

______________________________________ ______________

SIGNATURE OF PATIENT OR PARENT / LEGAL GUARDIAN *DATE*