Acknowledgement of privacy practices

SOUTHMOOR PEDIATRIC DENTISTRY, P.C.
SouthmoorKids.com

I acknowledge that a copy of the Notice of Privacy Practices for the office of Southmoor Pediatric Dentistry is available to me upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or the performance of office health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

Southmoor Pediatric Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, a copy of the revised Notice of Privacy Practices may be provided to me upon request.

I, _____ , authorize Southmoor Pediatric Dentistry to disclose my protected health information to only the persons indicated below.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Signature of Patient or Guardian _____ Date _____