Highlands Dental

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I have received a copy of the Notice of Privacy Practices for Highlands Dental.

_____
Print Name

_____ _____
Signature of Patient (or personal representative) Date

If there is anyone that you would like to designate to be allowed to receive communication about your dental treatment please enter their name below and sign. If not, please leave this section blank.

I hereby designate the following individuals to receive communications from Highlands Dental that may include dental/medical information about me.

I authorize Highlands Dental to leave voice mail messages concerning my health information (i.e. proposed treatment, appointment instructions, etc.)

Their Name: _____

Their Phone Number: _____

_____ _____
My Signature Date

If this acknowledgment is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____