BRIGHT SMILES
OF BEACON

PRIVACY PRACTICE NOTICE (HIPPA)

Section A: The Patient

Name: _____

Address: _____

Telephone: _____E-Mail: _____

Social Security Number: _____

Section B: Acknowledgement or Receipt of Privacy Practices Notice

I, _____ acknowledge that I have received a Notice of Privacy Practices from Tony Cruz- McLeod DMD.

Signature: _____ Date: _____

(If a personal representative signs this authorization on behalf of the individual, Complete the following)

Personal Representative Name: _____

Relationship to Individual: _____

Section C: Permissions

May we discuss personal information with: (please check the following)

☐ Parents ☐ Children ☐ Spouse

Signature:

I attest that the above information is correct

Signature: _____ Date: _____

Print Name: _____ Title: _____

Include this acknowledgement in individual's record