# Acknowledgement of Notice of Privacy Practice

We keep a record of the health care services we provide you. By my signature below, I acknowledge receipt of the Notice of Privacy Practices for Clearwater Dental. We will not disclose your record to others, unless you direct us to do so or unless the law authorizes or compels us to. Our Privacy Practices describes in more detail how your health information may be used or disclosed, and how you can access your information. You may ask to see and copy that record at any time.

Patient _____ Date _____

Legally Authorized Individual Signature _____

**Authorization to disclose Medical / Dental Information to a Family Member or Designated Person.**

By my signature below, I give my written permission to allow the providers and staff of Clearwater Dental to share my dental / health information with:

Family Member / Designated Person(s) _____

Relationship _____ Phone # _____

I understand that this notice may be revoked at any time upon receipt of written request.