ACKNOWLEDGE OF RECEIPT OF PRIVACY NOTICE

A copy of Short Pump Dental **Notice of Privacy Policies,** detailing how any information on file may be used and disclosed as permitted under federal and state laws, has been made available to me.

____ request a copy

____ do not want a copy

DISCLOSURES TO FAMILY MEMBERS AND FRIENDS CONSENT

I, _____, understand that information may be made to my family and friends related to my dental health or for financial purposes. I understand that my doctor will only discuss information relevant to current treatment. I agree that my doctor may disclose health information to the following:

Name	Relationship
1.	
2.	
3.	
4.	

Patient Signature _____Date _____