

Patient Name: \_\_\_\_\_

**Elizabethtown Dental Associates**  
**Notice of Privacy Practices**

\_\_\_ I acknowledge that I have received the Elizabethtown Dental Associates Notice of Privacy Practices that describes how my dental and medical information may be used or disclosed as required by federal law.

\_\_\_\_\_  
Signature  
(If patient is a minor, please sign name of parent or guardian)

\_\_\_\_\_  
Date

***Permission to Discuss Dental Information***

The privacy of your dental and medical information is very important to us. If you wish us to discuss information about your medical condition to your family, friends, caregivers, or others, please indicate this by completing the information below.

I, \_\_\_\_\_, permit the discussion of my healthcare information for the purpose of communicating results, findings, care decisions and billing/payment information to the following individuals:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

I understand that dental practice personnel will use their professional judgment to determine if the discussion is in my best interest if I am not present, incapacitated or in an emergency situation and that this authorization will remain in effect until revoked by me in writing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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***For Office Use Only***

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- \_\_\_ Individual refused to sign
- \_\_\_ Communication barriers prohibited obtaining acknowledgement
- \_\_\_ An emergency situation prevented us from obtaining acknowledgement
- \_\_\_ Other \_\_\_\_\_