CONWAY SARDINA
Cosmetic and Family Dentistry

# HIPAA NOTICE OF PRIVACY PRACTICES

• We are required by law to maintain the privacy of Protected Health Information and provide individuals with this Notice of our legal duties and privacy practices with respect to Protected Health Information.

Your signature below is an acknowledgement that you have received this

**Notice of our Privacy Practices.**

By signing this form you are also allowing our office to:

- Confirm appointments at your home/cell by phone or answering **Machine/voice mail;**
- Disclose medical dental information requested by other treating physicians and dentists;
- Leave messages or discuss medical information with your pharmacist;
- Disclose medical dental information to your insurance company;
- Disclose medical dental information with our dental lab;
- Request medical dental records when necessary from physicians or dental offices.

I hereby give permission to disclose health information about me to the following people: (please print name on the line provided)

Spouse: _____

Son/Daughter: _____

Mother/Father: _____

Other: _____

**I have the right to withdraw or revise my permission at any time, in writing.**

Print Name: _____

Signature: _____ Date: _____