Eastview Dental Professionals

HIPAA

Notice of Privacy Policies

Last Name: First Name: Birthdate:

Is there a family member or friend that you would authorize our practice to discuss your Protected Health Information with? If so, please list those individuals below:

Authorized Individuals: ______________________________

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By signing below, I hereby acknowledge that I have been provided with a copy of this office's notice of privacy practices and have therefore been advised of how my protected health information may be used and disclosed to the office and how I may obtain access to, and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

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Signature

Date: