

Notice of Privacy Policies

Last Name: _____ First Name: _____ Birthdate: ____/____/____

Date: _____

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

I give my permission to Alani Dental Center to contact the following individuals on my behalf, in regards to:

___ Billing and Insurance Issues

___ Medical Issues

___ Both

Name: _____

Name: _____

Name: _____

Patient Signature _____