ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

HIPAA Authorizations Form

I, _____ authorize the following people access to my private dental/health information upon request (i.e. treatment plan, financial information, treatment history). My signature below acknowledges that I have given authorization to Dr. Dutton's office to speak with the people listed:

_____

_____

_____

_____

Dental Materials Fact Sheet

My signature below acknowledges that I have read and been provided with a copy of the Dental Materials Fact Sheet:

_____ _____

Signature of Patient or Patient's Representative Date