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Acknowledgment of Receipt of Privacy Practices

I have received and understand Black & Black Dental's Notice of Privacy Practices. The notice provides in detail the use and disclosure of my protected health information that may be made by the practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Patient Name (printed)

Date of Birth

Patient Signature

Today's Date

Permission of Release of Information to another Party

I, "patient listed above", grant permission to release my information to the following person listed below....

Name of Other Party

Relationship to Patient

Patient's Initials