NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT ONLINE CAREFULLY.
www.fifthstreetdentalames.com

I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION FORM ONLINE AT WWW.FIFTHSTREETDENTAL.COM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEATH INFORMATION AS DESCRIBED IN THIS FORM.

DATE:

PATIENT NAME:____

PATIENT SIGNATURE____

IF YOU ARE SIGNING AS A PERSONAL REPRESENTATIVE OF THE PATIENT, DESCRIBE YOUR RELATIONSHIP TO THE PATIENT AND THE SOURCE OF YOUR AUTHORITY TO SIGN THIS FORM:

RESPONSIBLE PARTY NAME____

RESPONSIBLE PARTY SIGNATURE____