Acknowledgment of HIPPA Privacy Practices

I, _____have been given the chance to read and review Galleria Dental of Alexandria HIPPA notice of Privacy Practices.

_____ _____

Signature Date

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALHT INFORMATION

I authorize Galleria Dental to release health information only if necessary for the course of my treatment. This information may be used for consultation, medical treatment or other purposes. I understand that Galleria Dental of Alexandria will not at anytime release my personal information for any other reason other than to pursue dental treatment options by my choice.

I understand that I retain the right to revoke this authorization at anytime in writing.3

_____ _____

Signature Date