NOTICE OF PRIVACY PRACTICES & DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I give permission to share my Protected Health Information with: (Please initial applicable authorization)

____ No one

____ The following person(s):

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

I understand I have the right to revoke this authorization at any time by contacting the office of Millennium Dental. Phone number: (972)491-2677.

I have the right to review the Protected Health Information to be used or disclosed or to refuse to sign this authorization.

By signing this form, I acknowledge that I have been provided with a copy of the office's "Notice of Privacy Practices". I authorize Millennium Dental to use and disclose my Protected Health Information regarding my care.

PATIENT SIGNATURE: _____ DATE: _____

PRINTED NAME: _____