Young Dental, LLC recognizes that every patient has the Right of Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

By signing this Acknowledgement:

You are only confirming that you have been offered a copy of our PRIVACY PRACTICES (located on bulletin board in entry way).

You do not give up any of your Rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health.

I have received a copy of Young Dental's Notice of Privacy Practices.

_____ _____

Print Patient Name Date

_____

Patient Signature (Parent or Guardian signature if a minor)

AUTHORIZATION AND RELEASE OF INFORMATION

If you would like to designate anyone for us to speak to (besides your doctor and insurance company) about your appointment times, your account, or your care, please list their names below. This will remain in effect until you revoke this authorization in writing. The HIPAA privacy law allows us to speak to other doctors and insurance companies regarding treatment. If you do not wish to list anyone please put NONE on lines 1 and 2, and we will speak to no one other than your doctor and insurance company regarding your care at our facility. In addition, if medically necessary, I authorize the release of information acquired in the course of my examination and treatment.

1.) _____ _____

Name Relationship to Patient

2.) _____ _____

Name Relationship to Patient

_____ _____

Patient Signature (Parent or Guardian signature if a minor) Date