

**Notice of Privacy Practices for Protected Health Information**

Notice of Privacy Practices for Protected Health Information Consent

Patient's Name: \_\_\_\_\_

I, \_\_\_\_\_, hereby acknowledge that I have received a copy of 58 Dental's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

The following persons may be contacted concerning my care or in payment of such care.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_