**Smith Center Dental Clinic**

**108 West Kansas Smith Center, KS 66967**

**Phone: 785-212-8282**

**HIPPA**

Name of Patient Date of Birth

**Acknowledgement:**

I am aware of the Notice of Privacy Practices at Smith Center Dental Clinic. I understand that I may or may not choose to read the Privacy Practices.

Signature Date

**Permission:**

I hereby give permission to discuss my protected health information (PHI) with the following individuals (please fill in names):

Spouse:

Children:

Other:

Patient Signature Date Signed

Patient Legal Representative Signature Date Signed

Relationship of Legal Representative to Patient