REVISION 8/15/2018

MINDEN DENTAL CLINIC

110 East Hawthorne • Minden, NE 68959

PHONE: 308-832-2582 • FAX: 308-832-1120 • www.mindendentalclinic.com

HIPPA

NAME OF PATIENT _____ DATE OF BIRTH _____

Acknowledgement:

I am aware of the Notice of Privacy Practices at Minden 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 _____

PRACTICE VALUES: **A Foundation For Your Dental Health Care**

COMPASSION/CARING • INTEGRITY/SINCERITY • PURSUIT OF PERFECTION • DESIRE OF KNOWLEDGE