Smile Makers
David M. Fry, Jr., DMD FAGD PC
John W. Barganier, DMD PC
Christina Hawkins Cox, DMD
and Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

Name: _____
DOB: _____
Social Security #: _____

I authorize the following for reminders my appointments:

- ☐ Open Correspondence
- ☐ Messages at work Wk # _____
- ☐ Messages on cell Cell # _____
- ☐ Text Messages Cell # _____
- ☐ Messages at home Hm # _____
- ☐ Email Email _____
- ☐ Postcard Card _____

I authorize person(s) to whom my medical information may be released:

Name	Relationship	Contact #

I have read the consent of this authorization form and I agree with all statements made. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/organizations named in this form.

X _____ X _____
Signature of Patient (Guardian) Date

I acknowledge receipt of the Notice of Privacy Practices form which details how Protect Health Information may be used and disclosed, and how I may access that information.

X _____ X _____
Signature of Patient (Guardian) Date

SUBMIT