Ionia Family Dentistry
Notice of Privacy Practice Acknowledgement

**** I grant Ionia Family Dentistry permission to release/discuss any dental or insurance information to the following people:**

Spouse of Patient? __ No __ Yes If yes, name: _____

Parent(s) of Patient? __ No __ Yes If yes, name(s): _____

Other? Please list name: _____
For parents or guardians only:
If you would like to apply this permission to more than 1 patient (children), please list the following names of the patients:

_____

****I grant Ionia Family Dentistry permission to leave a message on my answering machine for the following reasons:**

Appointment Date and Time and/or Missed Appointments? __ No __ Yes
Insurance information/billing/financial concerns? __ No __ Yes
Prescriptions/Lab results? __ No __ Yes

****I grant Ionia Family Dentistry permission to share my dental records to other medical or dental professional offices if I am a mutual patient.**

****I acknowledge I have read the above information and I have also read or received a copy of the Ionia Family Dentistry Notice of Privacy Practices.**

_____ _____

Patient (or Guardian) Signature Date