

**PERSONAL CARE DENTISTRY**  
**7046 Torresdale Avenue, Philadelphia, PA 19135**  
**Phone: 215-335-4955**

Dear Patient,

Please be advised that we are required by law to maintain the privacy of, and provide individuals, with the notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak to our office in person or at our main number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practice.

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

Print Patient Name \_\_\_\_\_

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In accordance with the new federal regulations regarding patient's privacy, please read and sign the following:

I \_\_\_\_\_ give permission to Personal Care Dentistry to do the following:

- Confirm appointments by phone
- Leave messages on answering machine to confirm appointments
- Release medical information requested by another treating dentist, physician or health institution
- Give permission for Personal Care Dentistry to request records as needed from other dentists, physicians and/or institutions to assist in my ongoing treatment.

The following person is authorized to receive medical and dental information about me, the patient, in the event I am not available:

Contact name \_\_\_\_\_

Phone # \_\_\_\_\_ Relationship to contact \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_