



Eberhardt Dental *Family Dentistry with a Cosmetic Touch!*
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HIPPA Privacy Notice Acknowledgement

I, _____, acknowledge that I have received a copy of the Eberhardt Dental Privacy Notice.

Additionally, I give permission for Eberhardt Dental to contact other Physicians, Dentists, and Allied Healthcare regarding my dental / medical care.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, relationship to patient: _____

I give permission to Eberhardt & Eberhardt, DMD to leave message at my house regarding office appointments or exam results.

_____ yes

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