Notice of Privacy Policies for the office of Robert Miracle, DMD, PC

Last Name: First Name: Birthdate:

Date:

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

SIGNATURE of Patient (Parent or Guardian if under 18 years of age)