Patient's Printed Name:_____

Patient's Date of Birth:_____

By signing below, I authorize Delgado Orthodontics to use and/or disclose any protected health information (PHI) to the following (i.e. spouse, grandparent, etc.):

_____ _____

Name of person receiving information Relationship to Patient

_____ _____

Name of person receiving information Relationship to Patient

Once my health information is given to the above listed person(s), I understand that it is possible that it may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing to: Delgado Orthodontics
9293 Huntington Square
North Richland Hills, TX 76182
Attention: Privacy Manager

How did you hear about us? _____

Notice of Privacy Practices

Acknowledgement of Review

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative :_____
Date:_____

Printed Name of Patient or Personal Representative:_____

Description of Personal Representative's
Authority:_____