Fisher Dentistry

Bradford B Fisher, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this Consent. The terms of our Notice may change, you can request a copy at any time. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand by signing this consent I authorize you to use and disclose my protected health to carry out,

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of our practice.

I, _____, have reviewed a copy of this Office's Notice of Privacy Practices.

Name (Printed): _____ Date: _____

Signature: _____