Patient's HIPAA Acknowledgement Form

I, ____________________________, acknowledge that I received and reviewed the office Privacy Policy Notice for Dr. Jennifer Hathaway, D.D.S., F.A.G.D.

I give permission to Dr. Hathaway and her staff for communication with my family member(s) or other responsible adult regarding my dental care.

Patient signature: **X**____ Date: _________

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: ____

Relationship to Individual: ____

In case you do not agree to sign this form, our office must indicate why you declined to do so.

Reason for patient's refusal:

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Privacy Director's Signature: ________________________________ Date: __________

Jennifer Hathaway, D.D.S. • 1719 Broadmoor • Bryan, Texas 77802 • (979) 776-6884