

Family Dental Center

Acknowledgement of Release of Information

**** You May Refuse To Sign This Acknowledgement****

I, _____ give permission, by signing this document, to Dr. Glen Magyera and the staff of Family Dental Center to discuss my oral health and my account information with the person(s) hereto: _____, _____, _____, _____. I further waive my privileges pursuant to HIPPA regulations in conjunction with this document and forever hold Dr. Glen Magyera and the staff of Family Dental Center harmless with respect to discussing my oral health with the abovementioned person(s).

Patient Signature: _____

Patient Name Printed: _____

Date: _____

Witness: _____(Office Use Only)