Reyes Dental Group

PRIVACY PRACTICES STATEMENT:
Acknowledgement of Receipt

Patient Name: (PRINT PLEASE) _____

Email Address: _____

I,_____, acknowledge that I have been offered a copy of the Notice of Privacy Statement from Larry G. Reyes, DDS PLC, and any questions I had, have been answered by the office staff.

My Rights:
I understand I do not have to sign this authorization in order to receive health care benefits, (treatment, payment or enrollment).

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the office of Larry G. Reyes, D.D.S., PLC based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are to fill out a revocation form, or to write a letter to the office.

Signature: _____Date: _____

You may disclose my health information to:

Full Name:_____
Phone: _____

Patient or legally authorized individual signature:_____
Date:_____