BLUE CEDAR
DENTISTRY

HIPAA POLICIES AND PRIVACY PRACTICES

I have reviewed this office's privacy policies and authorize the disclosure of my health information as described in the privacy practices notice.

Would you like a copy of our HIPAA Privacy Policies to review: YES   NO

Print Name____

Signature____DATE______

I give the following additional people permission to access my private health information:

1. ____

___All private health info

___Limited heath information access to: ______________________________

2. ____

___All private health info

___Limited heath information access to: _________________________________