

Dr. Keith Denton
Dr. Teresa Palmer
Dr. Graham Denton

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I, _____, was offered/have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ❖ Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- ❖ Obtain payment from third-party payers.
- ❖ Conduct normal health care options such as quality assessments and accreditation.

Preferred method of contact: Home / work / cell / text / email:

(Signature of Individual or Legal Guardian/Representative)

(Date)

Other person(s) allowed access to your health information:

None/Not applicable

_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship