Dr. David J. Hall, Jr. DDS, PA

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(919) 773-2266

ACKNOWLEDGMENT & RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for at least six years.

_____ _____

(Print) Patient Name Signature of Patient

_____ _____

Date Signature of Parent, Guardian or Patient's Legal Representative

AUTHORIZATION TO DISCLOSE PRIVATE HEALTH INFORMATION

List the name(s) below of any family member(s) or person(s) you wish to have access to your private health information at our office.

First Name	Last Name	Relationship

This authorization will remain in effect until written notification instructing us otherwise.