

Sierra Dental Group, P.A.

Pablo J. Sierra-Duque, D.M.D.
2333 Forest Drive
Inverness, FL 34453
(352) 726-2849

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT
FORM

I, _____ received a copy of Sierra Dental Group Notice of Privacy Practices.

Signature of Patient

Date

The following is not required; however, it is listed for your convenience if you wish to give us permission to discuss your medical condition with anyone you may designate such as spouse, children or caregiver. According to Florida Law, we are unable to discuss your medical condition, including medications, treatment plan, details about your care and certain appointments with your family or caregiver.

PERMISSION TO DISCUSS MEDICAL CONDITION WITH DESIGNATED PERSONS

I, _____, give permission for the staff and dentist to discuss my condition with the following: **(please give first and last name)**

___ Spouse _____

___ Children _____

___ Caregiver _____

___ Other _____

I understand I must notify Sierra Dental Group in writing if I no longer give permission for my medical condition to be discussed with the above person(s) or if I wish to add or change names.

Signature of Patient

Date