



## Notice of Privacy Practices

Stetzel Dental Group strives to maintain the strictest confidentiality of your medical and financial information. Our employees are all aware that this information belongs to you and you have the right to access this information. A detailed Notice of our Privacy Policies is available per your request. Please take the time to review the information and take a copy if you like. To better serve you, we need you to sign and date this form.

By my signature below, I acknowledge that I have had the opportunity to review Stetzel Dental Group's Notice of Patient Privacy Practices. I understand that a written copy is available upon my request.

\_\_\_\_\_  
**Print Patient Name**

\_\_\_\_\_  
**Patient Email Address**

\_\_\_\_\_  
**Patient/Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Staff Signature**

I hereby give authorization to disclose my private information to the following individuals:

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Relationship**