Dr. Andrew J. Smith, DMD & Dr. Nicholas A Smith, DMD
Notice of Privacy Practices (NOPP) and Permission to Disclose Health Information

Patient Name: _____

I have received a copy of this office's NOPP and I agree to this office's practices. This office may disclose my health information to a family member, personal representative, friend or other person to the extent necessary to help with my healthcare or with payment for my healthcare.

Please list the individuals below who we have your permission to share health information with.

NAME	RELATIONSHIP TO PATIENT	CONDITIONS OF ACCESS

_____

Signature of Patient: Date:

Office only:

- We attempted to obtain written acknowledgement of receipt of our NOPP, but acknowledgement could not be obtained.
- Individual refused to sing
- Communication barriers prohibited obtainment.
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please specify):