John E. Truitt, D.D.S, P.C.

Acknowledgement of Receipt of

Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Please print your name_____
Last First MI

Your Signature_____Date_____

Release of Information

I authorize release of any information relating to my/my dependent's treatment to and/or from my Insurance Company, Physician, Dentist, Hospital, College, and/or Immediate Family Members.

_____ _____
Patient's Signature (parent if a minor) Date

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