HIPPA ACKNOWLEGEMENT FORM

I_____have read and understand the Notice of Privacy Practice Document. I understand my rights as a patient of Artistic Smiles. I hereby give consent to Artistic Smiles/Dr. Robert Goldtrap to use my medical information as expressed in the Notice of Privacy Practice document.

Signature of Patient_____Date_____

Signature of Guardian_____Date_____

In addition, I give permission for the following individuals to be allowed access to my medical information, including: treatment, diagnosis, financial standing and appointment history.

NAME	RELATIONSHIP	PHONE #