PRIVACY ACKNOWLEGEMENT

Gary L. Riddle, D.D.S.

I acknowledge the receipt of Gary L. Riddle, D.D.S. Notice of Privacy Practices and have been provided the opportunity to review the information. I also give my permission to Gary L. Riddle, D.D.S. to discuss my dental records and/or financial account information with the following individuals(s)

Print Patient Name ____

Patient Date of Birth ____

Patient Signature ____ Date _____________

Patient Email Address ____

1. Family/Friend ____

   Phone Number ____

   Relationship to Patient ____

   Access to Medical Information _______ Financial Account Information _______ Both _______

2. Family/Friend ____

   Phone Number ____

   Relationship to Patient ____

   Access to Medical Information _______ Financial Account Information _______ Both _______