2253 N. Loop 336 W., Ste. A | Conroe, TX | 77304

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

____
Name (Please Print Legibly)

____
Signature

____
Date

CONSENT TO RELEASE PATIENT DENTAL INFORMATION

I authorize and direct LORD FAMILY DENTISTRY to release the following dental information:

______Medical History/Medications

______X-Rays

______Proposed Treatment

______Completed Treatment

To the following:

Family member/Friend, **please specify name & relationship**

____

____

____

______**Release information to me only**

____________________________________ ____________________
Patient Signature Date