Nease & Higginbotham Orthodontics

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I, ______________________________, acknowledge that I have received a copy of the Notice of Privacy Practices from Nease & Higginbotham Orthodontics, PA.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

____ ____________________________
Signature of Patient Date

____ ____________________________
Signature of Patient Representative & Relationship Date
(required if patient is a minor or an adult unable to sign form)

The following individuals have my authorization to access my Protected Health Information

Name	Relationship	Full/Restricted Access (Restricted How)	Phone Number