

Notice of Privacy Policies and Disclosure Authorization

Moore Smiles

Date: _____

Patient Name: _____ Birthdate: _____

Disclosure Authorization

Is there any individual that we may speak with about your care, treatment or account information?
Yes NO

If yes, please list all individuals that apply below:

_____	_____
_____	_____
_____	_____

Patient Signature: _____ Date _____