AZ Cosmetic & Family Dentistry
5757 W. Thunderbird Road; Suite W300
Glendale , AZ 85306
(602) 439-1101 (602) 789-1653 (fax)

DISCLOSURE FORM

Patient Name: _____Date of Birth_____

I authorize and agree that Dr. Vasudha Narra may disclose my protected health information to the following individuals and / or answering devices unless and until I object to such disclosures, which must be provided in writing:

1._____ Relationship_____Phone #_____

2._____ Relationship_____Phone#_____

3._____Relationship_____Phone#_____

4. (initial) _____ DO NOT speak to any family members

5. Answering machine Phone #_____

(initial) _____ May leave detailed messages (initial) _____ DO NOT leave detailed messages

6. Cell phone #_____

(initial) _____ May leave detailed messages (initial) _____ DO NOT leave detailed messages

Preferred language ____ English ____ Spanish ____other_____

EMAIL ADDRESS_____

I hereby acknowledge that I can request a copy of AZ Cosmetic & Family Dentistry's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights I may contact the office directly. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

_____ Date: _____
Signature of Patient or Patient's Personal Representative

_____
Print Name of Patient or Patient's Personal Representative