CHERRY Oral & Maxillofacial Surgery
Bradley A. Cherry, D.D.S., M.D.

Privacy Policy (HIPAA)

Patient's Name: _____ Date of Birth: / /

Patient's Social Security Number: - -

Mailing Address: _____

Phone Number: [H] ( ) - [M] ( ) - [W] ( ) -

Acknowledgement of Receipt of Privacy Notice for Bradley A. Cherry, D.D.S., M.D.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

Signature of Patient or Legal Representative: _____ Date: / /

Request For an Exception to the Disclosure Rules Regarding the Release of Protected Health Information (PHI)

Date of Request: / /

I authorize the following people to be involved in my care. This consent for disclosure includes both health and financial information as it relates to my care.

Individual's Name (Please Print)	Relationship to Patient