Nancy A. Casey, D.M.D.
ORTHODONTIC ASSOCIATES
55 York Road
Warminster, PA 18974
215-674-0332
Fax 215-674-9722
www.casey4braces.com
info@casey4braces.com

ACKNOWLEDGEMENT OF AWARENESS AND/OR RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I, (patient) _____, (date of birth _____) have read the "Notice of Privacy Practices (HIPAA)" from Orthodontic Associates.

Patient/Guardian Signature _____Date_____

I authorize my personal dental health information to be disclosed to the following individuals, if necessary. (This is for Family/Caregivers. Treating Doctor names are not needed here)

NAME _____RELATIONSHIP_____PHONE_____

NAME _____RELATIONSHIP_____PHONE_____

NAME _____RELATIONSHIP_____PHONE_____

I authorize permission to contact me with confidential communications about dental care via

- Text # _____ YES NO
- Leave message on cell #_____ YES NO
- Leave message at home #_____ YES NO
- Leave message at work #_____ YES NO
- Email _____ YES NO

FOR OFFICE USE ONLY

As a staff member of Orthodontics Associates, the above patient/guardian has been made aware of our current "Notice of Privacy Practices (HIPAA)"

Staff member signature _____date _____