Grand Corner Dental
STANLEY A. SARGENT, DDS

## Notice of Privacy Practices Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your record to others unless you direct to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office manager.

Our ***Notice of Privacy Practices*** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or Legal Guardian: ______________________________ Date: ____________

Printed Name: ________________________________________________________

## Photos and Records Release

I, hereby give Dr. Stanley A. Sargent the absolute right and permission to use my photographs & x-rays for education and or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs. I authorize Dr. Stanley A. Sargent to release diagnosis & treatment information to physicians, other dentist, and to my insurance company.

Patient or Legal Guardian: ______________________________ Date: ____________