ERIC K. TAYLOR, DDS
Diplomate American Board of Periodontology
Implants and Periodontics

ACKNOWLEGEMENT OF RECEIPT OF PRACTICES PRIVACY NOTICE

I acknowledge that I have received, and/or reviewed the notice of the Privacy Practices of this office. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that this notice of the practices Privacy Practice is posted.

* _____ _____
Patient Signature Date

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

☐ Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
☐ Obtaining payment from third party payers (insurance company)
☐ The routine healthcare operations of the office
☐ Leaving messages of appointment times
☐ Discussing treatment/test results with your significant other.

* _____ _____
Patient Signature Date

_____
_____
_____

EDUCATIONAL PHOTOGRAPHY

I give my consent for Dr. Eric K. Taylor to use my dental photography for educational purposes and to share with my general dentist.

* _____ _____
Patient Signature Date

PHONE (248) 652-7300 FAX (248) 652-0637 www. EricTaylorDDS.com

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