

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Notification

Acceptance of Agreement

and

Medical Release form

James O. Glaser, DDS, P.C.
Iron Bridge Family & Cosmetic Dentistry
9510 Iron Bridge Road, Suite 100
Chesterfield, Va. 23832

Tel: (804) 768-7600 Fax: (804) 768-0115

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I also hereby grant the office of Dr. James O. Glaser permission to seek and obtain any medical records deemed necessary to complete dental treatment for me from

(Physicians name)

Patient's Name: _____
(please print)

Signature: _____
(signature of patient , parent/legal guardian)

If patient is unable to sign or is a minor, complete the following:

Relationship to patient: _____

Patient is a minor or is unable to sign because_____.

