ALABASTER SMILES
PEDIATRIC DENTISTRY

**LAURI M. WILLIAMS, D.M.D., P.C.**

**THIS FORM IS TO BE FILLED OUT YEARLY BY LEGAL GUARDIAN**

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of Lauri M. Williams, D.M.D., P.C. notice of Privacy Practices. Alabaster Pediatric Dentistry may use PHI in the following ways: Treatment, Payments, and Health Care Operations. We may contact you for appointment reminders by phone call, text, email and mail outs. For more information see our Notice of Privacy Practices located at our front office area.

**Signature of Legal Guardian _____**

**To give consent to disclose Health Care information to someone other than the Legal Guardian, please write their name and phone number below. (E.G. Family members, caretakers-They will be required to show photo ID at sign in)**

**Name:_____ Phone number: _____**

**Driver License No: _____ Relation to Patient: _____**

**Name:_____ Phone number: _____**

**Driver License No: _____ Relation to Patient: _____**

**Name:_____ Phone number: _____**

**Driver License No: _____ Relation to Patient: _____**

**Name:_____ Phone number: _____**

**Driver License No: _____ Relation to Patient: _____**

**Name:_____ Phone number: _____**

**Driver License No: _____ Relation to Patient: _____**