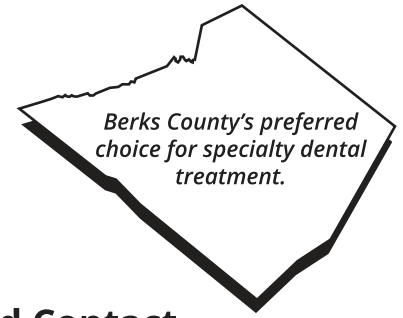




SCOTT BRAM, D.M.D. • BRIAN FREY, D.M.D.  
CHARLES GLOSSON, D.M.D.



## Privacy Practices & Permission to Discuss and Contact

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I have been given a copy of Berks Endodontics, Ltd. Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy by contacting the Practice Privacy Officer.

**My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:**

**I authorize** the disclosure of my Personal Health Information to the following individuals:

- **My Spouse/Partner**

Full Name and Phone Number:

\_\_\_\_\_

- **Family Members and Friends**

Specify Name, Relationship and Phone Number:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I understand/authorize Berks Endodontics to leave information about my appointment, my dental care, and financial information, and I wish to be contacted at the following numbers:**

Home Telephone: \_\_\_\_\_ Cellphone: \_\_\_\_\_

Work Telephone: \_\_\_\_\_

**COMPLETED BY:**

\_\_\_\_\_  
*Signature of Patient or Personal Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Print Name*