**Gary E. Smith, DMD**
**1417 Market Street**
**Charlestown, Indiana 47111**

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To All of Our Patients,

Due to the Notice of Privacy Practices, please be advised that Gary E. Smith, DMD and/or the staff members of his office are unable to discuss and/or disclose any or all information about you and/or all patients unless you have that person and/or persons name listed below. (To whom we are able to discuss and/or disclose information to).

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By signing this form you are confirming you have been provided a copy of our Notice of Privacy Practices. (You may request a paper copy of this Notice, if you so choose). You are also conforming that you understand we are unable to discuss and/or disclose any information concerning treatment, accounts, insurance, etc. unless that person and/or persons is listed above.

If you have any questions, please feel free to ask.

Thank you.

_____,
Patient's Name

_____, _____
Patient's/Patent's/ or Legal Guardian's Signature Date