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The undersigned acknowledges receipt of a copy of the facility; this is available to view at our front desk or onl	currently effective Notice of Privacy of Practices for the healthcare ine at www.chathamdentalarts.com .
My signature will also serve as a PHI document release doctor/facilities in the future.	should I request treatment or radiographs be sent to other attending
Please print name of Patient	Please sign for Patient/Guardian of Patient
Legal Representative/Guardian	Relationship of Legal Representative/Guardian
Please list any other parties who can have access to you any Care Takers, etc.)	ur health information: (This includes Step Parents, Grandparents, and
Name:	Name:
Name:	Name: