NOTICE OF PRIVACY POLICY
PAUL B GABRIEL, DMD

I have read and understand the HIPAA policy of the office and agree to have my protected health information on file with Dr. Paul Gabriel.

_____
Print Patient's Name

_____
Signature of Patient or Parent/Guardian Date

For patients over age 18:

I allow Dr. Gabriel and staff to discuss my dental conditions, healthiness, recommendations and if necessary, general health conditions and pharmaceutical needs to the following list of people. (Please list relationship, such as spouse, parent, guardian, grandparent, etc.)

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship