I have read and been offered a copy of the privacy practices for Chet A. Hymas, DMD PLLC.

_____ _____

Print Patient Name *Date*

_____ ☐**SELF** ☐**PARENT** ☐**GUARDIAN** ☐**LEGAL REPRESENTATIVE**

Signature of Responsible Party *Relationship to patient – Please Circle One*

I give my consent to allow the following person(s) access to my dental/medical information:

Name	**Relationship**	**initials**
_____	_____	_____
_____	_____	_____
_____	_____	_____