



**Anderson & Hoffner**  
**DENTAL CENTER**  
We smile when you smile.

**NOTICE OF PRIVACY**

In the event, that you may want a family member or friend to discuss your treatment with our office, we must have consent/permission in writing from you to do so.

Please list any person you give Anderson & Hoffner dental Center consent/permission to discuss your information such as account information, x-ray's, treatment, etc.

I \_\_\_\_\_, hereby give consent/permission to Anderson & Hoffner Dental Center to discuss any and all dental information with the named individuals below:

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

I \_\_\_\_\_, do not wish for Anderson & Hoffner Dental Center to discuss any of my dental treatment with anyone other than me.

Signature \_\_\_\_\_ Date: \_\_\_\_\_