Pueblo Dental Center

Patient Name				
AddressStreet		City	State	Zip
Telephone ()				
I acknowledge that I have received a	Notice of Privacy Prac	tices from Puel	olo Dental Mana	egement, Inc.
Signature		Date		
If a personal representative signs thi	s authorization on behalf	of the patient, p	olease complete	the following
Personal Representative's Name _	Please Print		1	
Relationship to the Patient				