Michael W. Lee, DMD, LLC

I _____ have received HIPAA Privacy Practice notice and give Dr. Michael Lee and all his associates my permission to communicate with:

My Doctors_____(initial)

My Insurance _____ (initial)

My Employer _____ (initial)

My School _____ (initial)

These other people:

Name: Phone:

Name: Phone:

Name: Phone:

Name: Phone:

SIGN:_____

DATE:_____

If for minor, minors name _____

We send statements to your email. Please provide us with an email address you would like to use for this purpose:

Email _____