Acknowledgment of Notice of Privacy Practices

[ ] I have received a copy of the notice of privacy practices for the Practice
(initial)

Name of Patient (Print or Type) _____

Signature of Patient _____

Date _____

(or)

Signature of Patient Representative _____
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient _____

Date _____

The Practice reserves the right to modify the privacy practices pursuant to its HIPPA privacy practices and procedures without further acknowledgment by the patient.

AUTHORIZATION TO DISCLOSE INFORMATION TO THIRD PARTIES

You have the right to authorize third parties to have access to your protected health information. Should you so desire, please indicate whom you would like to grant access to your protected health information by writing their name clearly below. You may revoke this authorization at any time by contacting the front office staff.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please initial this box [ ] if you are willing to permit the primary named insured on your health/dental insurance to have access to your protected health information.

Signature of Patient _____ Date _____

(or)

Signature of Patient Representative _____ Date _____