PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT LIMITED AUTHORIZATION & RELEASE FORM

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed dated document shall be as effective as the original. **My signature will also serve as a patient health information document release should I request treatment or radiographs be sent to other attending doctor facilities in the future.**

_____ _____ _____

Please **print** your name Please **sign** your name Date

Current Address: _____

Home Phone: _____ Cell: _____ Work: _____ Email: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS VIA:

☐ Home Phone ☐ Cell ☐ Work ☐ Email ☐ Any of the above

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents, and any care takers who can have access to your records)

Name: _____ Relationship: _____ Phone number: _____

HOW DO YOU PREFER TO BE ADDRESSED WHEN SUMMONED IN THE RECEPTION AREA?

☐ First Name Only ☐ Proper Surname ☐ Other _____

DENTAL INSURANCE AND HEALTH UPDATE:

Dental Insurance: _____

Any changes in your health? _____ New surgeries? _____ New medications? _____

Dental Concerns: _____

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.