Easton Bright Smiles
Cosmetic & Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient First Name_____Last Name_____DOB_____

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

** **You May Refuse to Sign This Acknolwedgement** **

By checking here ( ) and signing below, I acknowledge that I have read and agree to the above terms of treatment.

X _____ Date: _____
(Signature of Patient / Legal Guardian)

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself.

I, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Name: _____Relationship _____Phone#_____

Name: _____Relationship _____Phone#_____

Name: _____Relationship _____Phone#_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining the acknowledgement

( ) Other (Please Specify) _____