gregorywrightdds

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign This Acknowledgement

I have received a copy of this office's Notice Of Privacy Practices.

_____ _____

PLEASE PRINT PATIENT'S NAME DATE OF BIRTH

_____ _____

SIGNATURE OF PATIENT/GUARDIAN OF MINOR DATE

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
- Communications barriers prohibited us from obtaining acknowledgement.
- Other (Please Specity) _____

MEDICAL INFORMATION RELEASE

To be completed for ages 18 and older

I authorize the release of all medical information including but not limited to examination findings, diagnosis, x-rays and treatment to any dentist/physician I am referred to and to the following:

____Spouse _____

____Child(ren)_____

____Other_____ Relationship _____

____Information is not to be released to anyone.

_____ _____

SIGNATURE DATE