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Acknowledgment of Privacy Practices
Medical Information Release Form
HIPPA Release Form
You may refuse to sign this Agreement

Print Name:____ Date of Birth:___/___/___

We are unable to discuss your treatment with anyone unless you give us written permission.

[ ] I authorize the release of information including the diagnosis, records, images and examination rendered to me and claims information. This information may be released to specialists such as Orthodontist, Endodontist, Oral Surgeon, Periodontist, Etc.

Please note: Certain treatments may require the patient to be sedated. You will need to have a driver for such treatment. Your driver must be listed on this medical information release form prior to treatment.

[ ] Spouse Name: ____
[ ] Child(ren) Name(s): ____
[ ] Parent Name: ____

[ ] Other Name:*____
*Relation to Patient:____
[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages

Please call my [ ] Home [ ] Work [ ] Cell Number:_______________________________

If you are unable to reach me:
[ ] You may leave a detailed message
[ ] Please leave a message asking me to return your call
[ ] Other:__________________________________ between (time):__________________________

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

Signed:______________________________________ Date:____________________

Office Use Only

- We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
  - Individual refused to sign
  - Communication barriers prohibited obtaining the acknowledgement
  - An emergency situation prevented us from obtaining acknowledgment
  - Other (please specify)_______________________________________