Dentist ADK

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

The undersigned acknowledges a copy of the currently effective **Notice of Privacy Practices** for this healthcare facility is available upon request. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.**

Please health information:
Please list any other parties that can have access to your health information:

Name: _____ Relationship:_____

Name:_____ Relationship:_____

I authorize contact from this office to confirm my appointments, treatment & billing information via: (please cross off if you deny any of the below options)

Cell Phone	Home	Text	Email

Signature: _____ Date: _____