DARDENNE DENTAL ARTS

HIPAA PRIVACY FORM
Acknowledgement of Receipt of Notice of Privacy Practices

You reserve the right to refuse to sign this acknowledgement

I have received a copy or read the explanation of this office Notice of Privacy Practices. I acknowledge and allow Dardenne Dental Arts to share my information with the following people besides those already stated within the Notice of Privacy Practices.

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child_____

[ ] Other_____

[ ] No information is to be released to anyone.

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

Messages:
The best time of day to reach me: _____

Please call:
[ ]home phone_____ [ ]cell phone_____ [ ]work phone_____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave me a message asking for a return call
[ ] you may e-mail me at _____

_____ Date: _____/_____/_____
Print name

_____ _____
Signature Witness

Office use only: Patient refused to sign: (date) _____ staff member_____