HIPAA

ACKNOWLEDGMENT OF RECEIPT AND GENERAL CONSENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.
I authorize the dentist to release any information including the diagnosis and the records of any treatment rendered to me or my child to third party payors and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group.

FOR PATIENTS WHO ARE 18 YEARS OF AGE OR OLDER

I give permission to those listed below to have access to my medical information and to discuss matters related to my care. I recognize that if I do not list anyone below I am the only person who will have access to information regarding my medical information and care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____ Date: _____

Parent/Guardian Signature: _____