cedar place dental
FAMILY AND COSMETIC DENTISTRY

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ___________________________________, have reviewed a copy of this office's Notice of Privacy Practices. (seen a copy; A printed copy will be provided upon request)

____
Printed Name of Patient

____ ______________________________
Signature of Patient or Legal Guardian Date

AUTHORIZATION FOR RELEASE OF MEDICAL / DENTAL RECORDS

I hereby request and authorize the release of all information, without limitations, regarding any physical and mental condition, as revealed by your observation or treatment, past, present or future. This may include verbal or photocopies of my medical and/or dental histories, x-ray findings, diagnosis, treatment, prognosis and financial records.

I request that you release the information to:

1. ____ ____________________________
Name of Person(s) Relationship to patient

Cedar Place Dental may contact them by: ☐Phone ☐ Phone Message ☐Text ☐ Email ☐ Fax

Contact Information: ____

2. ____ ____________________________
Name of Person(s) Relationship to patient

Cedar Place Dental may contact them by: ☐Phone ☐ Phone Message ☐ Text ☐ Email ☐ Fax

Contact Information: ____

____ _______________________________
Patient Signature Date

Sign below to revoke authorization for _____________________________ effective: _______________

______________________________________ _______________________
Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policies, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An Emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify)