cedar place dental
FAMILY AND COSMETIC DENTISTRY

304 S. CLAIRBORNE ROAD, SUITE 100
OLATHE, KANSAS 66062
TELEPHONE (913) 764-6367
FAX (913) 764-6387

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003, the new federal law known as the Health Insurance and Portability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are offering you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

_____
Printed Name of Patient

I acknowledge that I have received, been offered a copy to review, or reviewed a copy of this office's Notice of Privacy Practices.

_____ _____
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

Contact Information: _____

2. _____ _____
Name of Person(s) Relationship to patient

Contact Information: _____

_____
Printed Name of Patient

_____ _____
Signature of Patient or Legal Guardian 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)

_____ _____ _____
Patient Name Office Personnel Signature Date