Patient Acknowledgement/Consent

I acknowledge that a copy of the Notice and Privacy Practices has been made available to me (copy available in our office). I also consent to your disclosure of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed on a separate sheet provided.

_______________________________ _______________________________ _____________

Patient Name (*Please print)* **Patient Signature (*Parent sign if minor*)** **Date**

HIPAA prevents us from disclosing any information about you to anyone (other than your medical and dental providers) without your permission.

To whom may we release information regarding your treatment?

Name: ____ Relationship: ___________________
Name: ____ Relationship: ___________________
Name: ____ Relationship: ___________________
Name: ____ Relationship: ___________________

In accordance with HIPAA guidelines, we must have permission to call you and/or leave a message. Please circle and update all of the ways we may get in touch with you.

Cell phone Home phone Email

For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement

An emergency situation prevented the patient from signing the Acknowledgement

______________________________ ___________________________

Office personnel (signature) Office Personnel (print name)

Date: __________________