MONTICELLO FAMILY DENTISTRY

Patient Acknowledgement of Receipt of Notice of Privacy Practices and Consent/Limited Authorization & Release Form

I acknowledge receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI (Personal Health Information) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITYS IN THE FUTURE.

I authorize contact from this office to confirm appointments, treatment & billing information via cell phone, home phone, work phone, text message or email. My health information may be conveyed via cell phone, home phone, work phone, text message or email.

_____ _____

Please print patient name Date

_____

Signature of patient/authorized representative

_____

Relationship to patient

Please list any other parties who can have access to your health information: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____ Relationship:_____
Name:_____ Relationship:_____

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.