

LOCKPORT DENTAL GROUP

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____, have received a copy OR read the explanation of this office's Notice of Privacy Practices.

(Signature of Patient and/or Guardian)

Date _____

Relationship to Patient (circle): Self or Other: _____

I, _____, acknowledge and allow Lockport Dental Group to share my information with the following people besides those already stated within the Notice of Privacy Practices.

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

No information is to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

The best time to reach me personally is (day) _____ between (time) _____

Please call my home phone my work number my cell number

If unable to reach me:

you may leave a detailed message please leave me a message asking for a return call

Signature: _____ Date: ____/____/____