Comfort Dental Care

Authorization for Release of Information

I, _____. Do hereby grant permission for Comfort Dental Care, to disclose my personal health information to the following personal representative (s) :

For example (spouse,sibling,parent,child, friend)

Name _____ Relationship_____

Name _____Relationship_____

Information to be disclosed:

___ Appointment dates/ Times

___Treatment plan and referrals

___Financial and Billing Information

I understand that this permission will remain in effect unless a written cancellation has been provided to Comfort Dental Care.

_____(Patient Signature) _____(Date)

Acknowledgement of Receipt of Notice of Privacy Practices

You may Refuse to Sign This Acknowledgement

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

_____ (Signature)

_____(Date)

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, 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)