

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)