COBB FAMILY DENTISTRY

Receipt of Notice of Privacy Practices & Personal Health Information Release Form
(HIPPA* Release *Form)
****You May Refuse to Sign This Acknowledgment****

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

Patient Name(Printed)*:*_____ Date of Birth:_____/_____/_____

Release of Information
***[ ]* I authorize the release of any and all information including the diagnosis, financial and dental records: examination rendered to me and claims information. This information may be released to:**

[ ] Spouse_____
[ ] Child(ren) _____
[ ]Other_____
[ ]Information is not to be released to anyone.

Uses and Disclosures of Health Information
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you

I understand that this office will try to accommodate my wishes about my contact information, but may have to contact me at the other numbers if unable to contact me at my requested number/location

Signature:_____ Relationship to patient _____ Date:____/____/____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledge could not be obtained because:

{ } Individual refused to sign

{ } Communication barriers prohibited obtaining the acknowledgement For Office Use Only

{ } An emergency situation prevented us from obtaining acknowledgement

{ } Other (Please Specify)

For Office Use Only