Acknowledgment of Receipt
of Notice of Privacy Practices

I acknowledge that I have been provided a copy of First Impressions Dental Care's Notice of Privacy Practices (posted in office), which has an effective date of September 15, 2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

____ ____________________
Signature of Patient or Patient's Representative Date

____
Print Name

____
Relationship to Patient (If not signed by the Patient)

Authorization to Disclose Information

I hereby authorize First Impressions Dental Care to disclose my Protected Health Information (PHI) including, but not limited to, appointments, x-rays, financial, and treatment to the following individual(s):

Name: __________________________________ Relationship: ____________________

Name: __________________________________ Relationship: ____________________

Name: __________________________________ Relationship: ____________________

I understand that I have the right to revoke this authorization, in writing, at any time. Unless otherwise revoked, this authorization shall remain in effect.

____ _________________________
Signature of Patient or Patient's Representative Date