AIRPORT ROAD DENTAL ASSOCIATES
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
**** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT ****

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

_____
{Please Print **Patient's** Name}

_____
Signature {Parent or Guardian for minors}

_____
Date

HIPAA Compliant Request to Allow Third Party Access to Patient Records

CROSS OUT IF NO ACCESS IS BEING GRANTED

Patient Name _____
(Address)
_____
_____

Third Party _____
(Address)
_____
_____

Description of the records to be released: All dental treatment provided at Airport Road Dental Associates, including past treatment, planned treatment, specialty referrals, appointment times, and all financial details. Request is in effect until withdrawn in writing by the patient or their guardian.

Signature of patient or guardian Date

Print Name
-

_____
_____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 acknowledgement

___ An emergency situation prevented us from obtaining acknowledgment

___ Other (please specify)
_____

_____

Rev 10/2014