EVANOFF DENTAL

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HIPAA Acknowledgement & Release Authorization

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request treatment information and x-rays be sent to other doctors or facilities in the future. *(You may refuse to sign this acknowledgment and authorization. In refusing we may not be allowed to process your insurance claims.)*

Name: _____ ❑ Patient ❑ Responsible Party **DOB:** _____

Signature: _____ **Date:** _____

Please list the names of any dependents:

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Please list any parties who can have access to your health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I hereby authorize _____ to provide copies of my dental records with respect to any dental care and treatment I have received. I understand that the specific type of information to be disclosed may include a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me. I understand that my dental records will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until revoked by me in writing.

Office to where records should be sent: _____

Address: _____

Phone: _____ Email: _____

Patient / Responsible Party Signature: _____ **Date:** _____