Account #:_____ Patient Name: _____

ACNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I have had full opportunity to read, understand the contents, and I have received a copy of this office's Notice of Privacy Practices. I understand that by signing this form, I am giving my consent for use and disclosure of my protected health information to carry out all payment activities and health care operations.

Patient's name _____ Date _____

Signature _____

Personal Representative's Name_____

Relationship to Patient_____

AUTHORIZATION FOR COMMUNICATION

I authorize Keystone Dental Group to release the following information about my health care (please check all that apply):

□ Any and all information

□ Information necessary to schedule, confirm, cancel, or reschedule appointments

□ Information about prescriptions

□ Information about my bills or account

□ I grant permission to this individual to bring my child to his/her appointments

This authorization applies to the following individual(s)

Name: Relationship to the Patient:

_____ _____

_____ _____

□ I choose not to authorize any individuals at this time

I understand that this authorization is valid until revoked by the patient, or the patient's parent/guardian.