PRIVACY FORM

Dr. D's Smiles

TODAY'S DATE _____

DACZKOWSKI ORTHODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____, HAVE RECEIVED A COPY OF THE OFFICE'S NOTICE OF PRIVACY PRACTICES.

_____

TYPE NAME HERE FOR ELECTRONIC SIGNATURE

_____

DATE

I AUTHORIZE THE PRACTICE TO GIVE MEDICAL INFORMATION ON _____ TO THE FOLLOWING INDIVIDUAL(S)

1. _____
2. _____
3. _____

☐ MY SUBMISSION OF THIS FORM CONSTITUTES ACCEPTANCE OF THE ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AUTHORIZING THE PRACTICE TO GIVE MEDICAL INFORMATION ON THIS PATIENT TO NAMED INDIVIDUALS ON THIS FORM.

_____ OR _____

TYPE NAME AS SIGNATURE FOR PATIENT **TYPE NAME AS SIGNATURE OF PARENT/GUARDIAN**

REFUSAL

IF PATIENT DOES NOT WANT TO SIGN, PLEASE SIGN ELECTRONICALLY YOUR REFUSAL TO SIGN THIS ACKNOWLEDGEMENT

_____ OR _____

TYPE NAME AS SIGNATURE FOR PATIENT **TYPE NAME AS SIGNATURE OF PARENT/GUARDIAN**