PRIVACY FORM

Dr. D's Smiles

DACZKOWSKI ORTHODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

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

PATIENT'S NAME

_____

PRINT FULL NAME HERE FOR SIGNATURE

_____

TODAY'S DATE

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

PATIENT'S NAME

1. _____
2. _____
3. _____

☐ MY SUBMISSION OF THIS FORM CONSTITUTES ACCEPTANCE OR 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 _____

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

REFUSAL

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

_____ OR _____

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