COWGILL DENTAL

Patient Name: _____

Notice of Privacy Practices

I acknowledge that I have received the Cowgill Dental Notice of Privacy Practices that describes how my health information may be used or disclosed as required by federal law.

_____ _____

Signature Date

HIPAA Permission to Discuss Dental Information

The privacy of your health information is very important to us. If you wish us to discuss information about your dental health with your family, friends, caregivers, or others, please indicate this by completing the information below.

I, _____, permit the discussion of my healthcare information for the purpose of communicating results, findings, care decisions, scheduling and billing/payment information to the following individuals:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

I understand that dental practice personnel will use their professional judgement to determine if the discussion is in my best interest if I am not present, incapacitated or in an emergency situation and that this authorization will remain in effect until revoked by me in writing.

_____ _____

Signature Date

_____ _____

Signature and Relationship to Minor Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other: _____