HAVEN FAMILY
DENTAL

HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy OR read the explanation of this office's Notice of Privacy Practices.

_____ _____

signature of Patient/Guardian Date

I, _____, acknowledge and allow **Haven Family Dental** to share my information with the following people besides those already stated within the Notice of Privacy Practices.

I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to :

( ) Spouse _____

( ) Child(ren) _____

( ) Parents/Other/Insurance _____

( ) No Information is to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

MESSAGES:

Please call ( ) my home phone ( ) my work phone ( )may text

_____ _____ _____

( ) you may leave a detailed message ( ) please leave a message asking for a return call

( ) you may e-mail me at _____

Signed: _____ Date: _____

Witness: _____ Date: _____