Breeze Dental Care
1330 YMCA Drive, Suite 400
Festus, MO 63028
Phone 636-937-3030 - Fax 636-937-3047

Acknowledgement of receipt of notice of this office's privacy practices (HIPAA)

You may refuse to sign this acknowledgement

I, ___________________________________, have been offered a copy of this office's notice of privacy practice.

____

Please Print Name

____ _____________________

Signature Date

For Office Use Only

We attempted to obtain a written acknowledgement of our notice of privacy practices from this patient, however the acknowledgement could not be obtained because……

- Individual refused to sign
- A communication barrier prohibited us obtaining thee acknowledgement
- An emergency situation prohibited us from obtaining the acknowledgement
  - Other (please specify) ____

Authorization for Release of Information to Other Individuals

Patient Name: _________________________________ Date of Birth: ___________________

If you would like to have your information to be shared with any other person, please list their name below and what Breeze Dental Care is allowed to disclose:

1.________________________ Relationship to Patient: _____________Phone Number _________________
2.________________________ Relationship to Patient: _____________Phone Number _________________

_______ Any and all protected health information; _______ Diagnosed and proposed treatment only;
______Financial only

_______ Other:____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

Patient Signature: ____ Date: ______________________