<u>STONEBRIDGE DENTAL</u>

AUTHORIZATION OF RECEIPT OF PRIVACY POLICY NOTICE AND FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

<u>SECTION A:</u> The Patient

Name: ____
Address: ____
Telephone: ____
Patient Number: _____________ Social Security Number: __________________________

<u>SECTION B:</u> Release of Identifying Health Information.

Name or names of individuals to whom information can be released: _____________________
____

<u>SECTION C:</u> Acknowledgement of Receipt of Privacy Practices Notice.

I, ____________________________, acknowledge that I have received a Notice of Privacy Practices from the above named practice.

Signature: _______________________________________ Date: ___________________
If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: ____
Relationship to Individual: ____

<u>SECTION D:</u> Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____________
____
____

Describe the reason why the individual would not sign this form: ________________________
____
____

<u>SIGNATURE:</u>
I attest that the above information is correct.

Signature: _______________________________________ Date: ___________________

Print name: ______________________________________Title:____________________