STONEBRIDGE DENTAL

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

SECTION A: The Patient

Name: ____
Address: ____
Telephone: ____
Patient Number: _________ Social Security Number: ___________________

SECTION B: Release of Identifying Health Information.

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

SECTION C: 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: ____________________________________

For Office Use Only:

SECTION D: 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: _________________
____
____

SIGNATURE:
I attest that the above information is correct.

Signature: ____________________________ Date: _____________

Print name: ___________________________Title:______________