HIPAA: Notice of Privacy Practices

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health & Human Services. We have elected to use this form. Prior to commencing your Dental treatment, you should review, sign and date this form.

Your protected health information & other biographical data may be used in connection with your treatment, payment of your account or health care operations. You have the right to review our office's privacy notice prior to signing this acknowledgement; a copy of which is available upon request.

Patient Name _____ Date _____

Signature of Patient/Parent/Guardian _____ Date _____

Reason for No Signature _____

Authorization for Release of Patient Information

I hereby authorize the doctor(s) of DentalPros to provide other health care providers with information regarding the individual's dental care as deemed appropriate. I understand that once released, the above doctor(s) and staff has (have) no responsibility for any further release by the individual receiving this information.

Patient Name _____ Date _____

Signature of Patient/Parent/Guardian _____ Date _____