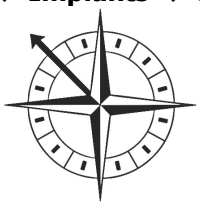
Northwest Periodontics & Dental Implants

◆ **LASER** ◆ **Implants** ◆ **Sedation** ◆



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ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
****You May Refuse to Sign This Acknowledgement****

Date: _____

I, (**Please Print Name**) _____ have received a copy of this office's Notice of Privacy Practices.

I authorize the release of medical/dental information including but not limited to diagnosis, records, x-rays, or treatment rendered to me and/or claims/account information. This information may be released to AND received from other dental/medical offices as well as the following individual(s):

Please check and give name of all that apply

[ ] Spouse: _____ [ ] Parent: _____

[ ] Child: _____ [ ] Other: _____

[ ] Or you prefer your information not to be released to anyone.
This release of medical/dental information will remain in effect until terminated by me in writing.

Please let us know how you would like us to *contact*/*confirm* your Scheduled Appointment Reminders

Please contact me: [ ] **Home**:_____ [ ] **Work**:_____ **Ext**:_____

[ ] **Cell**:_____ [ ] **Text Message**:_____

[ ] **E-Mail**:_____

[ ] You may leave a detailed message

[ ] Or _____

Signature of Patient/Patients Responsible Party:_____

***** Information provided is solely for the use of this office to help contact or confirm for appointment(s) scheduled.*****

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to:

- Individual refused to sign
- Communications barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement