



Northwest Periodontics

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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

(Over)