Patient Acknowledgement Form

I, _____ acknowledge that I have received and reviewed the office Privacy Notice for IDental Group.

_____ _____

Patient Signature Date

I, _____, authorize iDental Group to disclose and release my private and protected health information to the following person:

Name: _____ Relationship: _____

I authorize the following information to be disclosed (please select one):

A. My full health record (including but not limited to diagnostics, services, lab results, prognosis, treatment, billing information)
B. My health record as mentioned above, BUT I do not authorize for the following to be disclosed (please specify):

_____
_____
_____

_____ _____ _____

Name of person giving authorization Signature of person giving authorization Date

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I case you do not agree to sign this form, our office must indicate why you declined to do so. This office will not refuse treatment to anyone based solely on the patient's refusal to sign the acknowledgement form.

Reason for Patient's refusal:

_____
_____
_____
_____