Norman Family Dentistry

Patient Acknowledgement/Consent

I acknowledge that a copy of the Notice of Privacy Practices has been made available to me (Copy available in our office). I also consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed on separate sheet provided.

________________________ _____________________ __________

Patient Signature (*Parent sign, if minor)* Patient Name (please print) Date

HIPAA prevents us from disclosing any information about you to anyone (other than your medical and dental providers) without your permission.

To whom may we release information regarding your treatment?

Name: ________________________________ Relationship: __________________________

Name: ________________________________ Relationship: __________________________

Name: ________________________________ Relationship: __________________________

Name: ________________________________ Relationship: __________________________

In accordance with HIPAA Guidelines, we must have permission to call you and/or leave a message. Please circle below all of the ways we may get in touch with you.

Cell Phone Home Phone Work Phone Email Text

For office use only

Patient refused to sign.
The following circumstances prohibited the patient from signing the Acknowledgement:

An emergency situation prevented the patient from signing the Acknowledgement.

__________________________________ ____________________________

Office personnel (signature) Office personnel (print name)
Date:_______________________________