i Dental
Family Dentistry

MEDICAL and DENTAL RECORD AUTHORIZATION

I, _____, hereby authorize i Dental to disclose any information they possess concerning the medical or dental conditions of myself or _____, my dependent, including but not limited to, health histories, dental x-rays, examination findings, treatment proposals and options, treatment records, medications, and/or financial, billing, or account information to the following

Persons(s): _____ _____ _____

Relationship:_____ _____ _____

_____ _____

Signature of Patient, or Legal Guardian **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You May Refuse To Sign This Acknowledgement**

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

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

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specifiy)