Marie Albano D.D.S., Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ___________________________________

I, _______________________________ , have received a copy of this office's notice of privacy practices.

I hereby authorize DR. MARIE A. ALBANO, D.D.S. INC to obtain or release any and all pertinent information regarding my dental care, as needed, to assist in my ongoing treatment to or from other dental care specialists, health care providers, laboratories, or other institutions.

This authorization remains in effect until revoked.

Due to HIPAA Compliance Privacy Laws of the federal Government, it is mandatory that we ask you to review and answer the following questions:

1) May we contact you at your place of employment? YES NO

If so, may we leave a message? YES NO

Work Phone # ______________________________ Ext _____

2) Do you have any particular person or family member that you authorize to receive and discuss information regarding your personal health information? (example: general information, dental needs, billing etc.)

YES NO

Name: __________________________ Relationship ________________

Phone # ______________________ Other # ___________________

Is this person your Power of Attorney for medical purposes?
YES NO

Patient Signature: ___________________________________

Date: __________

Guardian/Representative Signature (If patient cannot sign or is a minor):

____

Date: __________