Notice of Privacy Practices
Jonathan P. Dacus, D.D.S.

You May Refuse to Sign This Acknowledgment
I have received a copy of this office's Notice of Privacy Practices

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
____Communications barriers prohibited obtaining the acknowledgement
____An emergency situation prevented us from obtaining acknowledgement
____Other (Please Specify)____

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Authorization for Use or Disclosure of Patient Information

Patient Name:______________________________Patient Date of Birth___/___/___

I hereby authorize the disclosure of my protected health information to:

_______________________________________Relationship to patient____________

_______________________________________Relationship to patient____________

_______________________________________Relationship to patient____________

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPPA Privacy regulations.

Signature of Patient of Patient's Personal Representative:

____Relationship_________Date____/___/____

Rev 4-15