ACKOWLEDMENT RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I **acknowledge** that I have been provided a copy of **The Smile Shack**'s Notice of Privacy Practices which has an effective date of ____/____/____ and which describes how my health information may be used or disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have

1. Been provided with a copy of the Notice of Privacy Practices
2. Been offered and refused a copy of the Notice of Privacy Practices
3. Been directed to review the poster of the Notice of Privacy Practices

____ ____________________

Signature of patient or patient's representative Date

____

Print name

____

Relationship to patient (If not signed by the patient)

Medical Information Release Form (HIPAA Release Form)

Name: ________________________________ Date of Birth: _____/_____/_____

[ ] I authorize the release of information including appointments, diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____
[ ] Child(ren)____
[ ] Other____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: ____________________________________ Date: ____/____/_____
Witness:____________________________________ Date: ____/____/_____