

ACKNOWLEDGMENT 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: ____/____/____