Bright Smile Dental Care

I have received copy of Bright Smile Dental Care's Notice of Privacy Practices___________________________.

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Please print name

___

Signature

___

Email Address

___

Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding your self covered under the Privacy Act to people other than yourself.

I authorize the following person(s) to have access to information covered under the Privacy practice regarding myself.

___

Please print name Relationship

___

Please print name Relationship

___

Please print name Relationship

For office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Practices.

_______ Individual refused to sign
_______ Communication barriers prohibited the acknowledgment
_______ An emergency situation prevented us from obtaining acknowledgment
_______ Other (Please specify)