ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement.

Patient Name: _____ Date: _____

- I have been offered and/or received a copy of the currently effective Notice of Privacy Practices for CORNERSTONE DENTAL.
- I understand that I may request a copy of the privacy policies at any time.
- I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party.
- My signature will serve as a PHI document release should I request treatment or radiographs be sent to other attending doctors in the future.
- A copy of this signed, dated document shall be as effective as the original.
- Expiration: 3 years from initial signature; insurance change; patient reaches age of 18.

_____ _____

Please ***print*** your name Please ***sign*** your name

☐ Patient ☐ Parent ☐ Guardian ☐ Other:_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation _____
- ☐ Home Phone Confirmation _____
- ☐ Work Phone Confirmation _____
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation _____
- ☐ U. S. Mail / Postcard

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** BE CONVEYED VIA:

- ☐ Message on Cell Phone
- ☐ Message on Home Phone
- ☐ Message on Work Phone
- ☐ Text Message
- ☐ Email Message
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW DENTAL INFO** via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**