ORTHODONTIC
SPECIALISTS
DR. JESSICA FALK

Acknowledgement of receipt of notice of Privacy Practices

This form is used to obtain acknowledgement of receipt of our notice of privacy practices or to document our good faith effort to obtain that acknowledgement.

You may refuse to sign this form

I, ______________________________ have been made aware of this office's Notice of Privacy Practices and have received a copy of the Notice of Privacy Practices if I have so requested.

____

Please print name Date

____

Signature Date

****

I, ______________________________ the undersigned, hereby authorize Orthodontic Specialists, doctor and staff, to share any and all dental and financial information with the following individual(s) on behalf of myself or my child, ______________________________.

Name: ________________________ Relationship to Patient: ___________________

Name: ________________________ Relationship to Patient: ___________________

Name: ________________________ Relationship to Patient: ___________________

Name: ________________________ Relationship to Patient: ___________________

☐ At this time I do not authorize anyone other than parent/guardian.

I understand that authorization to anyone other than myself and child's other parent is voluntary and I can revoke authorization at any time:

Authorized by: _______________________________ _________________________________

(Patient/Parent Name) (Print Name)