WEBER FAMILY DENTISTRY

Acknowledgement of Receipt of Privacy Practice Notice

***** You may refuse to sign this form

I _____, have received a copy of this offices Notice of Privacy Practices.

_____ Date_____

please print name

_____

Signature

For patients under the financial care of a parent: If you are or will be 18 years of age within the next two years, would you like to give permission for Weber Family Dentistry to discuss treatment and or payment for services with your parent/guardian/guarantor of your insurance? Declining **will not** affect your eligibility for benefits or treatment.

I, _____, grant permission to Weber Family Dentistry to release information to the following people regarding _____ treatment rendered/recommended

_____ account information

_____Date_____

Name ___Parent ___Guarantor

_____

Name ___Parent ___Guarantor

This release will remain effective from today's date to _____, or age 26 . I understand I may revoke this authorization in writing at anytime for the date of revocation forward.

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained.

___ Refused to sign ___ Communication Barrier ___Emergency Situation ___Other