LAWS DENTAL

ADVANCED FAMILY DENTISTRY
1775 SPRINGDALE BLVD • FENTON, MO, 63026
636-296-8080

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

I have received the Notice of Privacy Practices on this visit or a previous one. I understand I can request another copy at any time.

_____

First Name MI Last Name Date of Birth

_____

Signature of Patient/Parent or Legal Guardian Date

PATIENT RECORD OF DISCLOSURES

IN GENERAL, THE HIPAA PRIVACY RULE GIVES INDIVIDUALS THE RIGHT TO REQUEST RESTRICTION ON DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE INDIVIDUAL IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF (PHI) MAY BE MADE BY ALTERNATIVE MEANS SUCH AS: SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE OR CELLPHONE, INSTEAD OF THE INDIVIDUAL'S HOME PHONE.

PLEASE CHECK ALL THAT APPLY:

HOME TELEPHONE:
___ LEAVE MESSAGE WITH DETAILED INFORMATION
___ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

WORK TELEPHONE:
___ LEAVE MESSAGE WITH DETAILED INFORMATION
___ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

WRITTEN COMMUNICATION:
___ OK TO MAIL TO: _____
___ OK TO FAX TO: _____

CELL PHONE:
___ LEAVE MESSAGE WITH DETAILED INFORMATION
___ LEAVE MESSAGE WITH CALL BACK NUMBER ONLY

I GIVE CONSENT TO THIS OFFICE TO RELEASE ANY AND ALL TREATMENT OR FINANICAL INFORMATION TO THE PERSONS LISTED BELOW:

NAME	RELATIONSHIP	PHONE NUMBER

THIS DOCUMENT WILL BE A PART OF YOUR MEDICAL RECORD