THE DENTAL CENTER OF THE VALLEY
760 W NORTHLAND AVENUE
APPLETON, WI 54914

HIPAA

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

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed to* process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** as Patient or Guardian of Patient

_____

Date

_____

Please print name of Guardian/Legal Representative and Relationship

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

Name:_____Relationship: _____

Name:_____Relationship: _____

Name:_____Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO

CONFIRM MY APPOINTMENTS, TREATMENT, HEALTH and/or **BILLING INFORMATION VIA**

_____Home/Cell Phone

_____ Work Phone

_____ Text or Email