Skutak Dental, S.C.

HIPAA

PATIENT ACKNOWLEDGEMENT of RECEIPT OF NOTICE - HIPAA PRIVACY PRACTICES ACT CONSENT and AUTHORIZATION FORM RELEASE OF INFORMATION FORM

Patient Name (print)**: _____ Date: _____**

The undersigned acknowledges receipt of a copy of this healthcare facility's currently effective Notice of Privacy Practices. A copy of this document shall be as effective as the original and is available by request.

*_____ _____

Patient or parent/guardian/legal rep. *signature** **Print name of parent/guardian/legal rep.**

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, DISCUSS TREATMENT, HEALTH and/or BILLING INFORMATION VIA:

_____ Home Phone _____ Work Phone _____ Cell Phone

_____Text Message _____ Email _____ **ANY OF THESE CONTACT POINTS**

MY SIGNATURE WILL ALSO SERVE AS A RECORDS RELEASE AS NEEDED.

Email: info@skutakdental.com Phone: 715-355-4433 Fax: 715-355-4414