PROSTHO.
ENDO.
Bethesda | Rockville | Vienna

NOTICE OF PRIVACY PRACTICES

I acknowledge the receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated 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 attending doctors/facilities in the future.

I authorize the following individuals (example: spouse, parent/grandparent, sibling) to have access to and be informed of this patient's dental/medical information and dental/medical care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you do not list anyone, we WILL NOT share any information regarding your account.

In signing this HIPAA Patient Acknowledgement Form, I acknowledge and authorize, that this office may recommend products or services to promote my improved health. This office may or may not receive third party remuneration from these affiliated companies. This office, under current HIPAA Omnibus Rule, will provide me with this information with my knowledge and consent.

Patient Signature: _____Date: _____

Signature of Guardian/Authorized Representative: _____