POTTS ORTHODONTICS

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address_____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature of Patient or Parent/Legal Guardian — Date

_____ _____
Witness — Date

_____
For Office Use Only
_____

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- Δ An emergency existed & a signature was not possible at the time.
- Δ The individual refused to sign.
- Δ A copy was mailed with a request for a signature by return mail.
- Δ Unable to communicate with the patient for the following reason:

  _____

- Δ Other: _____

  _____

Prepared By_____

_____ _____
Signature — Date

Potts Orthodontics
Christopher C. Potts DMD PA

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form authorizes Potts Orthodontics (Name of Practice) to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ **Main Contact Number:** (___) _____
mm/dd/yyyy ☐ Home ☐ Cell* ☐ Work

COMMUNICATING WITH YOU

PHONE	DETAILED MESSAGES PERMITTED		
☐ Main Contact Number Above	☐ text (SMS)*	☐ voicemail/answering machine	☐ None
☐ Other: (___) _____ ☐ Home ☐ Cell* ☐ Work	☐ text (SMS)*	☐ voicemail/answering machine	☐ None

EMAIL*

☐ All information from this practice	
☐ Appointment information only (no treatment info)	

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

Spouse/Partner: _____
First and Last Name
Phone: (___) _____
Email:* _____

Other: _____
First and Last Name
Phone: (___) _____
Email:* _____
Relationship: _____

Check the box next to each type of information this practice may share.

☐ All information ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance ☐ Other: _____

☐ This practice may **NOT** communicate with my family members, friend, or caregivers.

I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

YOUR PHOTOS & MULTIMEDIA

Photos/Images may be used/posted -Photos taken by staff (e.g., pre/post procedure)

☐ In office
☐ On office's website
☐ Other: _____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

_____ _____
Patient/Personal Representative Signature Date

Description of Personal Representative's authority (e.g., healthcare power of attorney)
(Attach necessary documentation if not previously provided)

FOR OFFICE USE & REFERENCE ONLY

This authorization has been terminated: _____

The termination must be in writing and filed with the original authorization.
Date original signed authorization received: _____