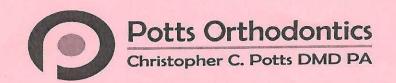
POTTS ORTHODONTICS

Acknowledgement of Receipt Of Notice of Privacy Practices

	ime & Address	
I have rece	eived a copy of the Notice of Pr	ivacy Practices for the above named practic
Signature of Patient or Parent/Legal Guardian		Date
Witness		Date
	nable to obtain a written acknov	ce Use Only vledgement of receipt of the Notice of Privac
Practices I		nature was not possible at the time.
Δ	The individual refused to sign.	
Δ	A copy was mailed with a requ	est for a signature by return mail.
Δ	Unable to communicate with th	e patient for the following reason:
Δ	Other:	
Prep	pared By	
	Signature	 Date



AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form authorizes Potts Orthodontics to communicate (Name of Practice) 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: mm/dd/yyyy Main Contact Number: () Home □ Cell* □ Wor							
COMMUNICATING WITH YOU							
PHONE	DETAILED MES	SAGES 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 N: Phone: () Email:*	ame	Other:First and Last Name Phone: (
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:		
P/	ATIENT 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:		