Legacy
Oral & Facial Surgery

Acknowledgment of Receipt of Notice of Privacy Practices
* You may refuse to sign this Acknowledgment

I, _____, have been afforded the opportunity to read this office's Notice of Privacy Practices.

_____ _____
Please Print Name Relation to Patient (self, parent, or legal guardian)

_____ _____
Signature Date

PATIENT AUTHORIZATION

In order for our practice to comply with HIPAA Federal Regulations, we ask that you read and sign this, so that we may provide you with the best care and treatment, while safeguarding your privacy.

If you have family and or a friend that will be calling requesting information, this MUST be signed by you, or no information regarding your care will be given to anyone other than yourself.

I authorize Drs. Brown Neuwirth & Munson to release my medical information to my personal patient representative(s).

Name of personal representative:_____
Date: _____Relationship: _____
Contact #: _____Contact #: _____

Name of personal representative:_____
Date: _____Relationship: _____
Contact #: _____Contact #: _____

<u>For Office Use Only</u>

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

____Individual refused to sign
____Communication barriers prohibited obtaining the acknowledgment
____An emergency situation prevented us from obtaining acknowledgment
____Other (please specify)
_____
_____
_____