

Mona Lisa Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

HIPPA Privacy Authorization Form

I authorize the disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patients Name: _____

Signature: _____ Date: _____