Elizabeth Township
FAMILY DENTISTRY

Acknowledgement of Receipt of Notice of Privacy Practices

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Elizabeth Township Family Dentistry
510 Simpson Howell Rd., Elizabeth, PA 15037
Phone: 412-754-0524

You May Refuse to Sign This Acknowledgment

I have been provided the opportunity to read and receive a copy of this office's Notice of Privacy Practices.

Patient's Name (please print): _____

Signature: _____ Date: _____

If acknowledgement is by patient's personal representative:

Personal Representative's Name (please print): _____

Relationship to the Patient: _____

I certify that I have the legal authority under applicable law to act on behalf of the patient identified above.

Signature of Personal Representative: _____ Date: _____

If you would like a copy of our Notice of Privacy Practices for your personal records, please:
ask our staff for a copy to go!

It is our office policy not to allow cell phones, video recorders or cameras into our clinical areas, this is to ensure that our patient privacy is kept at all time. We apologize for any inconvenience this may cause you.

FOR DENTAL OFFICE USE ONLY

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify): _____

Medical Information Release Form

Effective October 1st, 2018

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

(From Instructions: Place initials in appropriate boxes [ ] , Sign form on bottom)

Release of Information

[ ] I authorize the release of information including the diagnosis, records, billing, examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____

[ ] Information is not to be released to anyone.

Messages

Messages may be left by employees of Dr. Andrea Burns or an Automated Messaging Service

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message
[ ] you may text a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day)_____ between (time)_____

Emails

[ ] I Authorize **Dr. Andrea Burns** to email me pictures of the patient(s) and x-rays, appointment reminders, school excuses, and statements and receipts.

Pictures

[ ] I Authorize **Dr. Andrea Burns** to use pictures of the patient(s) for in office use and on business related social media

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Authorization:

Name: _____ Date of Birth: _____/____/_____

Signature: _____ Date: _____

This Release of Information will remain in effect until terminated by me in writing.