

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND APPOINTMENT REMINDERS FORM

I acknowledge that Smart Dental has provided me with a "Notice of Privacy Practices". I understand I have a right to review Smart Dental's "Notice of Privacy Practices" prior to signing this document.

Smart Dental's staff may need to contact you with appointment reminders or information related to your treatment. If this contact is made by phone, and you are not home, a message will be left on your answering machine or with whoever answers the phone. By signing this form you are giving us authorization to contact you with these reminders and information.

**My signature below also verifies that I have received, read and agree to the Office Policy and Procedures.**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Name (printed) Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Privacy Officer: Rose Turley Date

## **AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (OPTIONAL)**

I, \_\_\_\_\_, hereby authorize Smart Dental to use or disclose of my individually identifiable health information as described below. I understand that if the organization authorized to receive my information is not a health insurance plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

### **Persons/Organizations authorized to receive information: (please print)**

1.	4.
2.	5.
3.	6.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Signature Date