BOUDREAU FAMILY DENTAL
SMILE CARE FOR LIFE

JACQUES BOUDREAU, DMD
CYNTHIA YERED, DMD

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of this Dental Practice's **HIPAA Notice of Privacy Practices** has been made available to me**.**

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

-OR-

_____ _____
Signature of Personal Representative Date

Relationship of Representative to Patient (check one):

❑ Parent ❑ Guardian ❑ Power of Attorney ❑ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE FORM)

Patient Name: _____ Date of Birth: ___ /___ /_____

We are unable to discuss your treatment or account with anyone other than you without written permission. Please choose ONE option below:

❑ I authorize the release of information including diagnoses, records, examinations, appointments, outstanding balance and/or claims information.

This information may be released to:

Name: Relationship:

❑ My information is NOT to be released to anyone.

DENTAL OFFICE USE ONLY

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices,** but it could not be obtained because: _____

- ❑ An emergency prevented us from obtaining acknowledgement
- ❑ A communication barrier prevented us from obtaining acknowledgement
- ❑ The individual was unwilling to sign
- ❑ Other: _____

_____ _____
Staff Member Signature Date