DENTAL

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

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

I authorize the use of photographic images of my face and/or teeth for marketing and/or educational purposes. No names will be used unless express permission is given. I understand that I may revoke this authorization at any time, but such revocation must be in writing. Revocation affects disclosure moving forward and is not retroactive.

Signature: _____ Date: _____

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I, _____, give permission to Dr. Carly Klassen DDS ( W Dental) to disclose and release my protected health information described below to:

| Name(s): | Relationship: |
| --- | --- |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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Health Information to be disclosed: My complete dental health record, (including but not limited to diagnoses, xrays, prognosis, treatment, and billing). This information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons. This authorization shall be effective for all past, present, and future periods. (NOTE: You may revoke this authorization at any time by notifying Dr. Carly Klassen DDS in writing).

Signature: _____ Date: _____