STUART PROSTHETIC DENTISTRY

HIPPA

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I may obtain a copy of this practices' Notice of Privacy Practices at any given time. I have been given the opportunity to ask questions I have regarding this Notice.

Signature: _____ Date: _____

If you are the legal representative of the patient, please print the patient's name(s) and describe your relationship and authority.

Patient's Name(s): _____ Authority: _____

Patient's Name(s): _____ Authority: _____

AUTHORIZATION

Please list below the authorized representative(s) that we may speak with regarding your healthcare. You may at any time with written authorization, change or remove any and all representatives from this authorization. By completing this form, please be aware that you authorize the office of Stuart Prosthetic Dentistry to discuss any and all your healthcare needs including billing issues and questions with those listed below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____