Atlantic DENTAL GROUP
Comprehensive & Esthetically-Driven Dentistry

HIPPA Privacy Permission Form

By signing this form, I give Atlantic Dental Group permission to disclose my Protected Health Information (PHI) to the individuals listed below. The PHI that Atlantic Dental Group may disclose is limited to information directly related to that person's involvement in my health care or payment of my health care.

Name	Phone Number	Relationship to Patient

_____

PATIENT Name SS Number Date of Birth

_____

PARENT / GUARDIAN Name

_____

Mailing Address City, State, Zip

_____

Patient's or Guardian's Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement.

I, _____, acknowledge that I have received a Notice of Privacy Practices from Atlantic Dental Group.

_____

Signature Date

If personal representative signs this authorization on behalf of the individual, please complete the following:

Personal Representative's Name (please print): _____

Relationship to Individual (please print): _____

For Office Use Only

We attempted to obtain written acknowledgment of our Notice of Privacy Practices, as required by law, but acknowledgment could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibiting obtaining the acknowledgment
_____ An emergency situation prevented us from obtaining acknowledgment
_____ Other (please specify): _____