# HIPAA Form

Please keep the MIDTOWN DENTAL Financial Policy and the Notice of

Privacy Practices for your records and return this signature page to the front office.

**By signing below you acknowledge the office of Midtown Dental Financial Policy and the Notice of Privacy Practices. By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.**

CONTACT RELEASE INFORMATION: I agree to permit MIDTOWN DENTAL and

their business associates to contact me, and all other responsible parties on my

account.

Signature: ____________________________________________________________

Patient Name: __________________________________________________________

Patient Representative (if minor):__________________________________________

Date: ___________________________

**I release the following phone number to be contacted concerning voicemail or text:**

(______)________-_________

**Listed below are the people that can know about my patient information:**

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgments
- An emergency situation prevented us from obtaining acknowledgements
- Other (Please Specify)