AUSTIN ORAL & MAXILLOFACIAL SURGERY

07/2020

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB ___/___/____ Chart# _____

I acknowledge that Austin Oral Surgery provided me with a written copy of its Notice of Privacy Practices.
I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

AUTHORIZATION TO RELEASE INFORMATION TO THIRD PARTY

I authorize Austin Oral Surgery to release information to third parties, as follows: □ **None**

Name: _____ DOB ___/___/____ Relationship: _____

☐ No Restrictions.
☐ Limited (Please Specify)

_____
_____
_____

_____ _____
Patient Signature Date

_____ _____
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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
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_____
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Witnessed by: _____ Date: ___/___/____