

AUSTIN ORAL & MAXILLOFACIAL SURGERY

03/2020

Fred J. Voorhees, DDS, MSD
Travis W. Kern, DDS, MD
William C. Cain, DDS, MD
Robert B. Hunsaker, DDS, MD

Thomas S. Weil, DDS, MD
Andrea L. Quaroni, DDS, MD
Russell D. Cunningham, DDS, MD
Craig Knell, DDS, MD

Daniel Szalay, DDS
James C. Fuselier, DDS, MD
Michael P. Ding, DDS MD
Jeremy D. Leland, DDS, MD
Tyler C. Wildey, DDS, MD

Diplomates, American Board of Oral and Maxillofacial Surgery • Fellows, American Association of Oral and Maxillofacial Surgeons

38th Street – 512-454-6725
Cedar Park – 512-258-3764
LaGrange – 979-968-8510
Dripping Springs: 512-858-8080
www.austinoralsurgery.com

Mopac – 512-346-7949
Marble Falls – 830-798-1054
San Marcos – 512-396-4689
Pflugerville: 512-956-4466

William Cannon – 512-447-6684
Georgetown – 512-869-0529
Temple – 254-771-1167
Lakeway: 512-263-9544
Medlink (after hours) – 512-323-5465

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

Personal Representative Signature (if applicable)

Relationship to Patient

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 acknowledgement
 An emergency situation prevented us from obtaining acknowledgement
 Other (Please Specify)

Witnessed by: _____

Date: ___/___/___