AUSTIN ORAL & MAXILLOFACIAL SURGERY

10/2020

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