



NOTICE OF PRIVACY PRACTICES

1100 Peachtree St. N.E. Suite 680
Atlanta, Georgia 30309

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, hereby acknowledge that Dunson Dental Design (DDD) has given me the opportunity to read a detailed notice of the Privacy Practices. (A copy was presented to me in my New Patient Registration Packet, a printed copy is available upon request at the front desk)

Patient/Guarantor signature*: _____ **Date:** _____

***If patient is a minor (under the age of 18) form must be signed by a parent or legal guardian. ***

If not signed, please provide a reason why the acknowledgement was not obtained:

Witness (Staff) signature: _____ **Date:** _____

AUTHORIZATION TO RELEASE PROTECTED DENTAL INFORMATION

In the event I cannot be reached, I, _____, give permission for a representative from DDD to speak with the appointed person(s) listed below regarding my care or test results.

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Is it OK to leave results or other health information on your voicemail? _____ YES _____ No (Check One)

Patient/Guarantor signature*: _____ **Date:** _____

***If patient is a minor (under the age of 28), form must be signed by a parent or legal guardian. ***