



Date: _____

I HAVE READ AND UNDERSTAND THE HIPPA AUTHORIZATION FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

➡ Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____

Print Name _____

Source of Authority _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Williams' Notice of Privacy Practices.

Patient name _____

➡ Signature _____

I received a copy of the new patient letter concerning Williams Family Dentistry's approach to service and policies.

➡ Signed: _____

If you have any questions or concerns about these or any forms please feel free to visit the office during normal business hours or call 681-8888.

FOR OFFICE USE ONLY

We were unable to obtain the acknowledgement of receipt of the above notices because:

- ◇ An emergency existed and a signature was not possible at the time
- ◇ The individual refused to sign
- ◇ A copy was mailed with a request for a signature by return mail
- ◇ Unable to communicate with the patient for the following reason:

◇ Other: _____

Prepared by: _____

Signature: _____