ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement but, in refusing we *will not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **Little Smiles PC.** A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.

Patient(s) Name(s)

_____ _____

_____ _____

_____ _____

_____ _____

Parent/ Legal Guardian **Printed Name** Parent/ Legal Guardian **Signature**

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- □ Cell Phone Confirmation
- □ Home Phone Confirmation
- □ Work Phone Confirmation
- □ U. S. Mail / Postcard
- □ **Any of the above**

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** BE CONVEYED VIA:

- □ Message on Cell Phone
- □ Message on Home Phone
- □ U. S. Mail / Postcard
- □ **Any of the above**