Addison Dental Group

Robert D. Halbach, D.D.S., P.C.
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Phone 972/233-2111 Fax 972/233-6071 www.addisondentalgroup.com

Notice of Privacy Practices Acknowledgement

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices from Addison Dental Group / Robert D. Halbach, D.D.S., P.C.'s with respect to the Health Information Privacy Practice Act / HIPPA Policies and Procedures.

____
Patient Name (please print)

____ ____________________
Signature of Patient and/ or Parent/Guardian (if minor) Date

Addison Dental Group/Robert D. Halbach D.D.S., P.C. attempted to obtain written acknowledgement of receipt of notice of privacy practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communication barriers prohibited obtaining the acknowledgement

□ An Emergency situation prevented us from obtaining acknowledgment

□ Other (please specify)____

Dental Information Release

I hereby authorize Addison Dental Group/Robert D. Halbach, D.D.S., P.C. to release of information of my dental records to the following persons (i.e. spouse or dependants):

Name (please print) ______________________________ Relationship ____________________

Name (please print) ______________________________ Relationship ____________________

Name (please print) ______________________________ Relationship ____________________

Name (please print) ______________________________ Relationship ____________________

______________________________ ____________ ____________________
Signature of Patient or Parent/Guardian (if Minor) **Date** **Patient Name**