PRIVATE HEALTH INFORMATION AND COMMUNICATION
Ryan J. Platt, DDS and Abigail M. Platt, DDS

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, the undersigned, acknowledge that I have received a copy of the office's Statement of Privacy Practices.

Printed Name: _____

Signature:_____

Date: _____

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I authorize communication regarding my appointments, medical/dental information, and account information to the persons indicated below.

Name:_____ Relationship: _____ Phone #: _____

Name:_____ Relationship: _____ Phone #: _____

Name:_____ Relationship: _____ Phone #: _____

Name:_____ Relationship: _____ Phone #: _____

☐ I do not wish to allow any of my information to be shared with anyone.

AUTHORIZED METHODS OF COMMUNICATION

As my dental care provider, you may do the following with my permission:

☐ Contact my primary contact at #:_____

☐ Contact my secondary contact at #: _____

☐ Leave voicemails on the above #s

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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)_____