PRIVATE HEALTH INFORMATION AND COMMUNICATION (MINOR)

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.

☐ My Parents

NAME:_____ PHONE #: _____

☐ My Caregiver

NAME:_____ PHONE #: _____

☐ Other

NAME:_____ 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)_____