CONTEMPORARY DENTAL ARTS, P.C.
75 TALCOTT RD, SUITE 60
WILLISTON, VT 05495

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

You May Refuse To Sign This Acknowledgement

I, ______________________________________ have received a copy of this office's Notice Of Privacy Practices.

____

Signature

____

Signature of Parent Or Guardian (If Under Age 18)

____

Date

I ALLOW AUTHORIZATION TO SHARE INFORMATION WITH THE FOLLOWING INDIVIDUAL(S):

Full Name/Relationship: ____
Full Name/Relationship: ____

This information is to include:
† Any of my medical/dental information.
† My appointment times, dates, and reasons for the visits
† The medications I am taking
† Insurance Claims/Billing Information

I understand that I may cancel this consent at any time (by writing to Contemporary Dental Arts), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical/dental provider or my clinic to share information with someone.

Signature: ____ Date: ____________