

WACO ORAL SURGERY

2/2021

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Diplomates, American Board of Oral and Maxillofacial Surgery • Fellows, American Association of Oral and Maxillofacial Surgeons

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB ___/___/___ Chart# _____

I acknowledge that Austin Oral Surgery provided me with a written copy of its Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

AUTHORIZATION TO RELEASE INFORMATION TO THIRD PARTY

I authorize Austin Oral Surgery to release information to third parties, as follows: **None**

Name: _____ DOB ___/___/___ Relationship: _____

- No Restrictions.
- Limited (Please Specify)

Patient Signature

Date

Personal Representative Signature (if applicable)

Relationship to Patient

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Witnessed by: _____

Date: ___/___/___