832.604.7737
PUREDENTALSTUDIO1@GMAIL.COM
PURE DENTAL STUDIO

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

Section I

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

Section II

I would like to give the above healthcare organization permission to:

- Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions. (Form of Disclosure: Electronic copy or access via a web-based portal.)

Section III Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s):

- ☐ Dental Insurance Company (medical as well if needed)
- ☐ _____
- ☐ _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to: Pure Dental Studio, 9101 Jones Rd. Ste A, Houston, TX 77065
Puredentalstudio1@gmail.com

_____

Print Name

_____ _____

Signature Date

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 prevented us from obtaining acknowledgement
__ Other (Please Specify)