Deland Implant Dentistry

Dr. Rajiv Patel, B.D.S., M.D.S.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices from **Dr. Rajiv R. Patel** on this_______ day of_________, 20___. A copy of this signed, dated Acknowledgement shall be effective as the original.

____

PLEASE PRINT YOUR NAME PLEASE SIGN YOUR NAME DATE

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority:

____.

Thank you and if you have any questions about this form or the attached notice, please contact our privacy officer.

Office Use Only As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledge but did not because:

- ☐ It was emergency treatment.
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because:________________________.
- ☐ Other (please describe) _____________________________________.

Signature of Privacy Officer____.

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ATHORIZATION TO DISCUSS HEALTHCARE ISSUES

________________________________ ________________

Patient Name Date of Birth

I hereby authorize **Dr. Rajiv Patel** and/or his other staff members to discuss my healthcare issues with the following person(s):

Name: ________________________________ Relationship:___________

Name: ________________________________ Relationship:___________

Name: ________________________________ Relationship:___________

Name: ________________________________ Relationship:___________

I understand I have the right to: - Receive a copy of this authorization

- Revoke this authorization

This authorization will remain in effect until the following date: _______ or until otherwise notified. (initials:____)

____

Signature of Patient/Legal Representative Relationship to patient Date