HIPPA PRIVACY AUTHORIZATION FORM

I authorize the office of Dr. Nickolas C. Arvan D.D.S., to use and disclose the protected health information described below to,
(Spouse, Parents, etc.)____.

I also authorize the office of Dr. Nickolas C. Arvan D.D.S., to provide appoint information to the following,
Cell: ______________________________

Email: ______________________________

Home: ______________________________

This authorization for release of information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Acknowledgement of receipt of Notice of Privacy Practices

I _________________________acknowledge that I have read and/or received this offices Notice of Privacy Practices.

____
Signature of patient or personal representative

____
Print name of patient or personal representative

____
Relationship to patient

____
Date

Office Use Only

We attempted to obtain written acknowledgement of receipt of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited us from obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify