Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

_____ _____ _____
PATIENTS SIGNATURE | If patient is a CHILD or REQUIRES A GUARDIAN | DATE

Privacy Practices Acknowledgement of Receipt

YOU MAY REFUSE TO SIGN THIS ACKOWLEGDEMENT

I, _____, have received a copy of this office's notice of privacy. I consent to the release of protected health information that is required to carry out treatment, payment, and /or healthcare operations on my behalf.

_____ _____ _____
Printed Name | PARENT/GUARDIAN SIGNATURE | DATE

Authorization to Release & Discuss Dental Information

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the "Do Not Release Information" below. Authorization to speak with family/friend (including spouse) I give the following named person(s) authorization to take messages or speak with the office of Alpine Dental, on my behalf regarding **(please check all items authorized).**

Name of authorized person: _____ Relationship _____
Phone number _____ ___Appointments ___Financial ___Dental Treatment ___Insurance

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____**DO NOT RELEASE INFORMATION TO ANYONE**

Authorization to leave Health Information by Alternate Means
I authorize the Alpine Dental staff to use the following telephone numbers I have provided to leave message on voice mail for reminder calls and other patient matters.
____Home Phone ____Cell Phone ____Work Phone

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider should I wish to change one or more contacts listed above.

_____ _____ _____ _____
Patient's Printed Name | Patient's Date of Birth | Signature of Patient/Parent/Guardian | 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: _____.