ACCELERATED DENTAL

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Acknowledgement and Disclosures to Individuals Involved in Patient's Care

You May Refuse to Sign this Acknowledgement

I acknowledge that I have received a copy of Accelerated Dental's Notice of Privacy Practices. By signing below, I consent to Accelerated Dental use and disclosure of protected health information about me for treatment, payment and healthcare operations. I also confirm that **I DO NOT** desire restriction on Accelerated Dental use or disclosure of protected health information for treatment, payment and healthcare operations.

Please Print Name _____

Signature of patient, parent, or legal guardian _____ Date _____

There may be times when it is necessary for an individual directly involved in your care to call our office to inquire about your personal health or billing information.

I authorized Accelerated Dental to disclose my health information that is directly related to my current treatment at Accelerated Dental to the following individuals, for purposes of their role in my treatment or payment for the dental services that I have received.

By listing these individuals and signing below, you hereby authorize Accelerated Dental to release personal health information to them.

Name _____ Relationship _____

Name _____ Relationship _____

Signature of patient, parent, or legal guardian _____ Date _____