Jennifer W. Chalker D.D.S., PLC

4104 Quarles Ct ~ Rockingham VA, 22801 ~ (540) 434-4343

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT & AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I,_____, hereby acknowledge that I have received and reviewed a copy of this office's **Notice of Privacy Practices**. I understand how this office will use my protected health information, understand my rights to privacy and how this will be used and disclosed. This notice may be revised and I understand that I have a right to request a paper copy of these revisions.

I authorize Jennifer W. Chalker D.D.S., PLC permission to discuss or release my dental records to the names listed below.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

OR

_____I do not wish to list anyone to receive my healthcare information.

Print Name:_____

Signature:_____ Date:_____
(If patient is under age 18, Parent/legal guardian must sign above and print name below)

Print Name of Parent/Legal Guardian:_____Relationship to patient:_____

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
( ) Communication barriers prohibited obtaining the acknowledgment
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other (Please Specify)

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