JAMES S. TRICHAK DENTISTRY
16841 N. 31st AVE., #140
Phoenix, AZ 85053

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____,
(**Please Print Name**)

have been shown and offered a copy of this Notice of Privacy Practices.

_____
Signature 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:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other

_____

_____

_____

OVER

AUTHORIZATION TO RELEASE INFORMATION

_____ _____

Patient/Guardian Date

Other than privacy disclosures necessary for treatment, payment and healthcare operations, I authorize Dr. James S. Trichak and his staff to discuss any and all matters pertaining to my/my child's dental treatment and/or account information with:

My parents _____ _____

Name Initial

My spouse _____ _____

Name Initial

Care giver _____ _____

Name Initial

Anyone in my family _____ _____

Name Initial

Other _____ _____

Name Initial

No one ********** _____

Initial

I can revoke this authorization in writing at any time, by requesting and signing a new form.

_____ _____

Patient/Guardian Date