JAMES S. TRICHAK DENTISTRY

16841 N. 31ST AVENUE, SUITE 140

PHOENIX, AZ 85053

(623) 938-4373

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 patient/guardian Date

for office use only

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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 Name 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 myself or my child's dental treatment and/or account information with:

My parents _____ _____
Name your initials

My spouse _____ _____
Name your initials

Caregiver _____ _____
Name your initials

Anyone in my family _____ _____
Name your initials

Other _____ _____
Name your initials

No one ********** _____
your initials

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

_____ _____
Patient, Parent or Guardian signature Date

****

This section is for updates only –please ask for a new form to make changes

No changes □ Initials _____ Date _____

No changes □ Initials _____ Date _____

No changes □ Initials _____ Date _____

No changes □ Initials _____ Date _____

No changes □ Initials _____ Date _____

No changes □ Initials _____ Date _____