



Patient Acknowledgement

Existing Michigan Law requires our office to first obtain a patients written consent prior to disclosing any of their written information, except for our disclosures in connection with: a defense to a claim challenging our professional competence, reviewing entities functions, claim payment of fees, third party payer's examination of our records, court order as a part of criminal investigation, identification of a dead body, licensure investigation, or child abuse/neglect investigation.

From time to time, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may refer or consult with another dentist or health care professional to provide a specimen to a laboratory for testing, or otherwise make disclosures in connection with providing and coordinating your treatment.

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES TODAY.

Patients Name: _____ (Please Print)

Patients Signature: _____ Date: _____

In order for office to be authorized to discuss treatment and business (billing) issues in person and/or over the phone on my behalf, that person MUST be listed below.

If patient is a minor, parent(s)/guardian(s) should also be listed also.

NAME OF PERSON: _____

Relationship to patient: _____

NAME OF PERSON: _____

Relationship to patient: _____

If health information that is NOT to be released or discussed with ANYONE other than the above patient, or the accompanying parent/guardian, please initial _____.

Signature: _____

Patient (or Parent/guardian of Patient)

Total Smiles: _____

witness