



Raleigh Prosthodontics
John A. Murrell, DDS, FACP
Hugh G. Murphy, DDS, MS
 Restorative & Prosthetic Dentistry

2605 Blue Ridge Road, Suite 310 Raleigh, North Carolina 27607
 (919) 510-4959 - Fax (919) 510-7989 - www.raleighpros.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices Acknowledgment of Receipt

Please complete Front & Back

ACKNOWLEDGEMENT OF RECEIPT

I, _____, acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me.

 Patient Signature

 Date

 Name of Minor Patient

 Parent, legal guardian or authorized rep. Signature

 Date

 Relationship to Patient

Due to current HIPAA Rules we will only discuss patient care with the patient or, if the patient is a minor, with their parent(s). Based on this current rule please complete the reverse side of this form.

For Office Use Only INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed by a Raleigh Prosthodontics representative only if no signature was received: Check the box below that describes why the patient or personal representative did not sign, or if the reason is not listed, please describe the reason in the Other reason section.

- | | |
|---|--|
| <input type="checkbox"/> An emergency situation prevented signature | <input type="checkbox"/> Other (Please Specify) |
| <input type="checkbox"/> Individual refused to sign | <input type="checkbox"/> A Copy was Mailed with a request for a signature by return mail |
| <input type="checkbox"/> Unable to communicate with the patient for the following reason: _____ | |

Prepared By: _____

Signature: _____ Date: _____

Revised March 2018

****Please complete Reverse Side**



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Authorization for Release of Information

Name of Patient _____ Date of Birth _____

The office of Raleigh Prosthodontics, Dr. Murrell & Dr. Murphy is authorized to release protected health information (PHI) about the above-named patient to the entities named below. The purpose of this form is to protect the patient's PHI.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Family Member/Other Person _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Dental Treatment <input type="checkbox"/> Appointment Reminders
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Appointment Reminders
<input type="checkbox"/> Email Communication-Provide email address** _____ For email communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. Please initial your choice	<input type="checkbox"/> Financial <input type="checkbox"/> Dental Treatment <input type="checkbox"/> Appointment Reminders _____ Encrypted _____ Unencrypted

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or receive a copy (copy may incur a cost) of the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect until revoked by the patient.

 Signature of Patient or Personal Representative Date _____

 Description of Personal Representative's Authority (attach necessary documentation)