Granite State Endodontics

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Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Please leave a phone number that you can be reached at to confirm/reschedule appointments, and to go over your insurance benefits. We would like your permission to leave a message with the number (s) provided in the event that there is no name mentioned on voice mail.

( )_____ ( )_____ ( )_____

Print Name: _____

Signature: _____

Date: _____

**** Authorization for the Release and/or Discussion of Protected Health Information ****

I am aware that information regarding my medical condition and or financial information will be released to those persons or agencies named below. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. _____
2. _____
3. _____