ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPAA PRIVACY PRACTICES

*****You may refuse to sign this acknowledgement*****

I, ______________________________, am acknowledging that the office of Dr. Anthony DiPasquale follows the Hippa Privacy Practices.

Signature ______________________________ **Date** ______________

Relationship to Patient ____________________

I, ______________________________, acknowledge and allow Dr. Anthony DiPasquale to share my information with the following people besides those already stated within the Notice of Privacy Practices.

- ☐ Spouse ____
- ☐ Child(ren) ______________________________________
- ☐ Other ____
- ☐ No information is to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

PERMIT FOR TREATMENT:

This is to certify that I, the undersigned, consent to the performing of the dental and or oral surgical procedures agreed to be necessary or advisable, including the use of anesthetics as indicated and I will assume responsibility for fees associated with those procedures.

____________________________________ ______________

Patient's (Parent's) Signature **Date**