

**Acknowledgement of Privacy Practices and HIPPA Consent**

Patient First Name: \_\_\_\_\_ Patient Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I have had an opportunity to read this office's Notice of Privacy Practices. I have also received this notice on behalf of my minor children listed below if applicable.

Names of my Minor Children: \_\_\_\_\_

\_\_\_\_\_

I authorize Gunnerson Dental to discuss my (and the minor children listed above) appointments, treatment, and financial information (including insurance information regarding coverage, payments etc.) relating to my account with the following individuals until permission is revoked in writing.

\*Please note\* If you wish for a spouse, significant other or child's parent to have access to your (or the children's) records, treatment plans and/or financial information, they MUST be listed below. If you would prefer to sign a privacy release form with specialized stipulations (such as access to children's appointment times but not financial records) Please call our office at (801)658-0102.

You may refuse to sign this acknowledgement.

Please List All HIPAA Authorized Individuals Below: This includes anyone who you would like to make a payment, change, cancel, or schedule reservations, or have access to your dental records. For example: your mom, dad, or significant other need to be added here.

Name of Authorized Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Name of Authorized Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Name of Authorized Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**Sign Form**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: \_\_\_\_\_

Relationship to Patient\*: \_\_\_\_\_