CHAUVIN & CHAUVIN, D.D.S., P.A.
816 LOWER DALLAS HWY.
DALLAS, N.C. 28034
(704)922-4147

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name _____ Date of Birth_____

I hereby acknowledge that I have received and reviewed a copy of the Notice of Privacy Practices for the above named practice explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligation concerning the use and disclosure of my protected health information.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:
  _____
- ☐ Other:_____

Prepared By _____

Signature _____

Date _____

CHAUVIN & CHAUVIN, D.D.S.,P.A.

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

At my request the following information may be released:

- ☐ Entire record
- ☐ Financial records
- ☐ Office visit notes
- ☐ On site record review by the patient
- ☐ Information results from test(s) or x-ray(s)
- ☐ Other as listed:

Entity or person(s) who will receive the information:

1. _____

2. _____

3. _____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that released information may include a communicable disease diagnosis such as HIV.

_____ Date _____

Signature of Patient or Personal Representative

Relationship to Patient _____

_____

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

Revised August 2013