JOSE I. ARAUZ
PRACTICE LIMITED TO PERIODONTICS AND DENTAL IMPLANTS
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Acknowledgement of Receipt of Notice of Privacy Practices
Authorization for Release of Information

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

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.
___Answering Machine / Voice Mail ___Text communication #_____ ___E-Mail communication _____	____ Scheduled Appointments
___Spouse (provide name) _____	____Financial ____Medical as follows: _____
___Parent (provide name) _____	____Financial ____Medical as follows: _____
___Other (provide name) _____	____Financial ____Medical as follows: _____

___for E-Mail and /or text communication I understand that if is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Patient Information
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect a copy 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 to disclosed as a result of this authorization may be subject to discloser 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 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: _____
Description of Personal Representative's Authority (attach necessary documentation)

For Office Use Only

We are unable to obtain a written acknowledgement of receipt jof the Notice of Privacy Practices because

_____An emergency existed & a signature was not possible at the time
_____A copy was mailed with a request for a signature by return mail
_____The individual refused to sign
_____Unable to communicate with the patient for the following reason_____

Other _____
_____

Prepared By _____ Signature _____

Date _____