THE RONTAL CLINIC

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I received a copy of The Rontal Clinic Notice of Privacy Practices and Financial Policy.

Print patient name: _____

Patient Signature: _____ Date: _____

Parent or Legal Guardian of a Minor child/patient _____

Date_____

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Authorization to discuss my medical record with other people:

In order for The Rontal Clinic to be **authorized to discuss** any treatment and business (billing) issues in person and /or over the phone on my behalf, that person MUST be listed below:

☐ I authorize The Rontal Clinic to discuss/release my health information to my primary care physician.

NAME OF PERSON: _____

Relationship to Patient_____

NAME OF PERSON: _____

Relationship to Patient_____

NAME OF PERSON: _____

Relationship to Patient_____

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Health information that is NOT to be released or discussed with ANYONE should be described here: _____

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This form should be updated (initial and re-dated) every year to remain valid, unless revoked in writing by the above patient or responsible parent or legal guardian.

Rontal Clinic Representative/Witness_____