JENKINS & MORROW
ORAL AND MAXILLOFACIAL SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.
(Print Patient Name)

_____ _____
Patient Signature or Parent/Guardian Signature Date

I understand that in order for information to be disclosed to anyone other than myself, I must give permission to W. Scott Jenkins, D.M.D., M.D., Nick S. Morrow, D.M.D. or David L. Wells, II, D.M.D., M.D. I give permission for W. Scott Jenkins D.M.D., M.D., Nick S. Morrow, D.M.D., or David L. Well, II, D.M.D., M.D., to discuss information regarding my care/treatment/account to the following listed persons.

(Please Print Names of all that apply.)

Parent/Guardian Name: _____
Spouse/Partner Name: _____
Referring Dentist/Doctor Name:_____
Friend Name: _____
Brother/Sister Name/s: _____
Child/Children Name:_____
Other: _____

Do not release or discuss my information with the following listed persons:
_____ _____
_____ _____

For Office Use Only

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other (Please Specify)_____