JENKINS, MORROW & GAYHEART

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., Nick S. Morrow, D.M.D., or Matthew N. Gayheart, D.M.D., M.D.

I give permissions for W. Scott Jenkins D.M.D., M.D., Nick S. Morrow, D.M.D., or Matthew Gayheart, 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) ____