



**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

I, _____, have reviewed a copy of the Vassey Dental Partners Notice of
Print Patient's Name
Privacy Practices.

Signature of Guardian/Patient DOB _____ Today's Date _____

MEDICAL INFORMATION RELEASE FORM

(HIPAA RELEASE FORM)

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____ Relationship _____

Information is not to be released to anyone.

Signature of Guardian/Patient Today's Date _____

This Release of Information will remain in effect until terminated by me in writing.