Robert L. Brookings, DMD
Practicing the Artistry of Dentistry

Notice of Privacy Practices – Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Office Manager, Barbara Prentiss.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Patient or legally authorized individual signature Date

_____ _____ _____
Printed Name if signed on behalf of patient Relationship (parent,etc) Patient Name

*Authorization for Release of **HEALTH RECORDS** to External Parties*

I authorize the disclosure of information from my treatment records to:

Name:_____ Relation:_____ Name:_____ Relation:_____
Name:_____ Relation:_____ Name:_____ Relation:_____

I understand that i may withdraw or revoke my permission at anytime. I may revoke this authorization by notifying the practice of Robert L. Brookings in writing.

_____ _____
Patient or legally authorized individual signature Date

_____ _____ _____
Printed Name if signed on behalf of patient Relation to patient Patient Name

*Authorization for Release of **PAYMENT RECORDS** to External Parties*

I authorize the disclosure of information from my payment records to:

Name:_____ Relation:_____ Name:_____ Relation:_____
Name:_____ Relation:_____ Name:_____ Relation:_____

I understand that i may withdraw or revoke my permission at anytime. I may revoke this authorization by notifying the practice of Robert L. Brookings in writing.

_____ _____
Patient or legally authorized individual signature Date

_____ _____ _____
Printed Name if signed on behalf of patient Relation to patient Patient Name