OCEAN GROVE FAMILY DENTISTRY, LLC
Dr. Dale C. Whilden and Dr. Sarah C. Brevet

Acknowledgment of Receipt of Notice of Privacy Practices and Authorization for Release of Information

I acknowledge that I have received a copy of this practice's Notice of Privacy Practices which provides a more complete description of how my protected health information may be used or disclosed. I consent to Ocean Grove Family Dentistry(OGFD)/Dr. Dale C. Whilden/Dr. Sarah C. Brevet using and disclosing my protected health information which may include laboratory results, x-rays, clinical findings or consultations, financial information and/or family billing information to carry out treatment, payment or dental care operations.

$I have the right to revoke this authorization at any time and to inspect or copy the protected health information to be disclosed by sending a written notification to this office.
$Such revocations are not effective in cases where the information has already been disclosed but will be effective going forward.
$I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
$I have the right to restrict how this office discloses my protected health information and understand that OGFD/Dr. Whilden/Dr. Brevet are not required to agree to the restrictions but would be bound by the restrictions to which they agree.
$ I may refuse to sign this authorization and my treatment will not be conditioned upon signing.
$This authorization will be in effect until I send a request to revoke it in writing to this office.
$OGFD/Dr. Dale C. Whilden/Dr. Sarah C. Brevet reserves the right to change their Notice of Privacy Practices. Revised notices may be obtained by written request to this office.

I authorize that voice messages containing personal health information, appointment confirmations,

etc. may be left for me at the following telephone number(s):_____

Other than necessary insurance companies, laboratories, other health care providers, financial or billing institutions or other entities required for ongoing care, please list any individuals that you give your permission to have your Protected Health Information:

No one other than myself. _____ (Please initial)

Name_____ Relationship_____ Restriction(if any)_____

Name_____ Relationship_____ Restriction(if any)_____

Name_____ Relationship_____ Restriction(if any)_____

Until further notice, signature of patient: _____ Date_____

Printed name of patient (or patient's representative): _____

Relationship of representative:_____

Office Use Only: Our practice has made a good faith effort to obtain a written acknowledgment of Receipt of the Notice provided to the individual. Written acknowledgment was not obtained because:

___individual refused to sign ___ individual unable to sign ___other (specify reason)_____

Employee signature_____ Date:_____