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ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(You May Refuse to Sign this Acknowledgement)

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____

(please print name) *(**Date of Birt**h: for identification purposes only)*

I hereby authorize Robert Waheed, DDS or Andres Ramirez, DDS Inc. to release the following personal health information *(PHI)*:

> ***Dental service claims information and payment of claims; Prescription, diagnostic, treatment, and/or care management services for insurance claims and referral purposes.***

MY CONSENT

I understand that consent may be revoked by me at anytime in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's **Notice of Privacy Practices**. I am also aware I may refuse to sign This Acknowledgement at any time.

Signature of Patient: _____ Date: _____

Legal Guardian or
Personal Representative: _____ Date: _____