Reid J. Calcott, D.D.S.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS / FACILITIES IN THE FUTURE.

I AUTHORIZE CONTACT FROM THIS OFFICE FOR **APPOINTMENT CONFIRMATION, PREMEDICATION REMINDERS, TREATMENT & BILLING INFORMATION.**
Preferred method of contact:

☐ Cell Phone ☐ Text Message
☐ Home Phone ☐ Email
☐ Work Phone ☐ Voicemail
☐ **Any of the Above**

Name of patient_____ Date of Birth_____

Please ***print*** your name _____

Please ***sign*** your name _____

Relationship to patient _____

Date _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any caretakers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

Signature of Privacy Officer_____