SUMMIT DENTAL GROUP
7555 Morgan Road, PO Box 2645, Liverpool, NY 13089
(315)457-0620

PART A: ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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

- Print Patient's Name ______ • Birthdate ______
- Parent/Legal Guardian/Personal Representative ______ • Relationship to Patient ______
- Signature ______ • Today's Date ______

For minor patients, this acknowledgment expires on the patient's 18th birthday.

PART B: AUTHORIZATION TO RELEASE INFORMATION

If you wish to allow us to discuss your dental care with someone other than yourself or a legal parent/guardian, please complete this section. Some examples include stepparents, grandparents and caregivers. If a person [other than yourself or a legal parent/guardian] is not listed below, they will be unable to gain access to personal dental health information, either written or verbal.

I authorize Summit Dental Group to release information regarding the diagnosis or treatment of dental, periodontal or orthodontic conditions to the persons named below:

- Name of Person ______ • Relationship to Patient ______
- Name of Person ______ • Relationship to Patient ______
- Name of Person ______ • Relationship to Patient ______

You may terminate this authorization by submitting a written revocation to the Summit Dental Group.

- Signature of Patient/Parent/Legal Representative ______ • Relationship to Patient ______ • Today's Date ______

For minor patients, this authorization expires on the patient's 18th birthday.

For Office Use Only

We attempted to obtain written knowledge of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)______