FAMILY DENTISTRY
OF CENTRAL CONNECTICUT

Acknowledgement of Receipt of Notice of Privacy Practices

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available online. If you prefer a paper copy, please ask a team member for a copy of our Notice.
I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature _____ Date _____

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I _____, Date of Birth_____, request that the following be followed for the disclosure of my Protected Health information (PHI). Protected Health Information would include your name, diagnosis and estimate of treatment that needs to be done, test results, dates of service, scheduled appointments, and your insurance information.
You may disclose information to my family members and or non-family members. Please list the name, phone number and relationship

NAME PHONE NUMBER RELATIONSHIP

_____

_____

You may leave Protected Health Information on my answering machine/voicemail. Phone Number: _____
Other: _____

_____
Patient's Printed Name

_____ _____
Patient's Signature (or Guardian, if minor) Date

_____ _____
Witness (optional) Date