Falls Family Dental

10450 Durant Road, Suite 102

Raleigh, NC 27614

Acknowledgement of receipt of Notice of Privacy Practices and Compound Authorization

************* **YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT** ***************

By signing below I acknowledge that I have received a copy of this office's Privacy Practices.

Patient Name: (Last) ____________________________ (First) __________________________ (MI) ________________

Address: ____

(City) ____ (State)______________ (Zip)__________________

________ I have been asked whether I choose to designate other persons/entities to receive my health or dentalinformation. I **do not** choose to designate such persons on the Compound Authorization form.

________ I give my permission for **Falls Family Dental** to release listed information to the entities named below.

- ❑ **Spouse / Significant Other** (Provide Name): ____
  - Financial Billing Information
  - Medical / Dental Information
- ❑ **Parent/ Family Member or Other** (Provide relationship and Name):_________________________________
  - Financial Billing Information
  - Medical/Dental Information
- ❑ **Employer / Workers Compensation** (Provide Name):____
  - Information about return to work and/or work restrictions and any absences that result from appointments.
- ❑ **School/ Preschool / Daycare** (provide name):____
  - Information about absences that result from appointments
  - Activity Restrictions

Signature: ____ Date: ____________________________

Patient Unable / Unwilling to sign Witness: ____

Revocation /Amendment

Name / Signature: ____ Date: ________________________

Reason for change: ____