

STAR
ORTHODONTICS
Steven Dickens, DDS, MS, PA
Christine Sirna Bode, DMD, MS

Authorization for Release of Information

Patient Name _____ Date of Birth _____

STAR ORTHODONTICS is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

ENTITY TO RECEIVE INFORMATION List each person that you approve to receive the information below.

PARENT/LEGAL GUARDIAN

Mom: _____ ☐ Financial ☐ Appointment/Treatment information

Dad: _____ ☐ Financial ☐ Appointment/Treatment information

(Please Print First & Last Name)

OTHER

Spouse: _____ ☐ Financial ☐ Appointment/Treatment information

Stepmom: _____ ☐ Financial ☐ Appointment/Treatment information

Stepdad: _____ ☐ Financial ☐ Appointment/Treatment information

Grandparent/Aunt/Uncle/Friend/ Guardian: **(circle)**

_____ ☐ Financial ☐ Appointment/Treatment information

(Please Print First & Last Name)

☐ Photo of patient received by patient or legal guardian ☐ May be posted in office

☐ Photo taken by staff (example: pre/post procedure ☐ May be posted on website

☐ Other ☐ May be posted on social media

Patient/Parent Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____/_____ Date_____

Signature of Patient or Personal Representative **Print name** of Patient or Personal Representative

Description of Personal Representative's Authority (Mother, Father, Legal Guardian) **please circle**

(ATTACH NECESSARY DOCUMENTATION IF LEGAL GUARDIAN)



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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name _____

Patient Address_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature **Date**

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- **An emergency existed & a signature was not possible at the time**
- **The individual refused to sign**
- **A copy was mailed with a request for a signature by return mail**
- **Unable to communicate with the patient for the following reason:**

  _____

- **Other:**_____

  _____

Prepared by (staff) _____

Signature of (staff)_____

Date_____