
Karen Bruggers, DDS, MS, PA

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Cary, NC 27518

Notice of Privacy Practices Acknowledgment of Receipt

ACKNOWLEDGEMENT OF RECEIPT Complete Front & Back

I, _____, acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me.

Patient Signature

Date

Name of Minor Patient

Parent, legal guardian or authorized rep. Signature

Date

Due to current HIPAA Rules we will only discuss patient care with the patient or, if the patient is a minor, with their parent(s). Based on this current rule please complete the reverse side of this form.

For Office Use Only
INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed by a Karen Bruggers, DDS, MS, PA representative only if no signature was received: Check the box below that describes why the patient or personal representative did not sign, or if the reason is not listed, please describe the reason in the Other reason section.

Physical/language barrier

An emergency situation prevented signature

Individual refused to sign

Other (Please Specify)

Prepared By: _____

Signature: _____ Date: _____

****Please complete Reverse Side**

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

The office of Karen Bruggers, DDS, MS PA is authorized to release protected health information (PHI) about the above named patient to the entities named below. The purpose of this form is to protect the patient's PHI.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Spouse/Family Member @ home phone	<input type="checkbox"/> Financial <input type="checkbox"/> Dental Treatment <input type="checkbox"/> Appointment Reminders
<input type="checkbox"/> Parent (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Dental Treatment <input type="checkbox"/> Appointment Reminders
<input type="checkbox"/> Other (i.e., Co-worker, Fiancé) (provide name) _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Dental Treatment <input type="checkbox"/> Appointment Reminders

Patient 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
 Description of Personal Representative's Authority (attach necessary documentation)

*****Please complete Reverse Side**
