

Health Insurance Portability and Accountability Act (H.I.P.A.A.)

Patient Name: _____

Acknowledgement of Receipt of Privacy Practices

I _____ received a copy of Dr. Robert S. Martin, D.M.D., P.A. Notice of Privacy Practices with an effective date of April 14, 2003.

Release of Information

I authorize the release of information including but not limited to; diagnosis, records, examination, and insurance information. This information may be released to:

- () Spouse _____
() Child(ren) _____
() Other _____
() Information is not to be released to anyone.

In the case of minor children; if divorce is involved, who is the custodial parent?

May patient information be released to the noncustodial parent? Yes No

The release of information will remain in effect until terminated by me in writing.

Messages

Please call: () Home () Work () Cell number

If unable to reach me:

- () you may leave a detailed message
() please leave a message asking me to return your call

Signature (if minor; parent or legal guardian): X _____ Date: _____

Signature of Witness: X _____ Date: _____