Raleigh Prosthodontics
John A. Murrell, DDS, FACP & Associates
Lauren Katz McKay, DDS, PhD
Restorative & Prosthetic Dentistry

2605 Blue Ridge Road, Suite 310 Raleigh, North Carolina 27607
(919) 510-4959 - Fax (919) 510-7989 - www.raleighpros.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices Acknowledgment of Receipt

Please complete Front & Back

ACKOWLEDGEMENT OF RECEIPT

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

_____
Relationship to Patient

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 Raleigh Prosthodontics 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.

_____ An emergency situation prevented signature _____ Other (Please Specify)
_____ 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: _____
_____

Prepared By: _____

Signature: _____ Date: _____

Revised May 2024

****Please complete Reverse Side**

Raleigh Prosthodontics
John A. Murrell, DDS, FACP & Associates
Laura Katz McKay, DDS, PhD
Restorative & Prosthetic Dentistry

2605 Blue Ridge Road, Suite 310 Raleigh, North Carolina 27607
(919) 510-4959 - Fax (919) 510-7989 - www.raleighpros.com

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

The office of Raleigh Prosthodontics, Dr. Murrell & Dr. McKay 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.
❑ Family Member/Other Person _____ _____	❑ Financial ❑ Dental Treatment ❑ Appointment Reminders
❑ Voice Mail	❑ Appointment Reminders
❑ Email Communication-Provide email address** _____ ❑ Text Messages – Can we communicate with you via text messages, from our office number?	❑ Financial ❑ Dental Treatment ❑ Appointment Reminders ❑ Yes ❑ No

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 receive a copy (copy may incur a cost) of 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 disclosure 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.

<u>This authorization shall be in effect until revoked by the patient.</u>

_____ Date_____
Signature of Patient or Personal Representative

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

Revised May 2024