KEVIN R. AUSTIN D.D.S., M.S., P.C.

ACKNOWLEDGMENT OF RECEIPT OF HIPPA PRIVACY POLICIES AND PROCEDURES

I, _____, have received and reviewed a
(Print name, Parent or Guardian if under age 18)

copy of this office's health information privacy and security policies and procedures.

Patient Name_____

Signature_____

Date _____

I hereby authorize the disclosure of individually identifiable dental health or account information to the following person(s):

_____

(Name) *(Relationship)*

_____

(Name) *(Relationship)*

_____

(Name) *(Relationship)*

_____

(Name) *(Relationship)*

_____

(Name) *(Relationship)*