DANIEL P. LAWRENCE, D.D.S. P.C.
620 Church Street
Sulphur Springs, TX 75482
(903)885-7726 Fax (903)885-1698

ACKNOWLEDGEMENT AND CONSENT OF NOTICE OF PRIVACY PRACTICES

AUTHORIZATION OF RELEASE

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I, _____, give permission to the office of Daniel Lawrence, D.D.S., P.C. to disclose my otherwise protected health information (which may include medical, treatment, diagnostic, financial records) to the following individuals:

Name of friends/family members you would like to give permission: _____

_____

_____

I understand that I may revoke authorization to the above named individuals at any time by written, dated communication. I have read and understand the nature of this release.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____.
Date

_____.
Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement.
☐ An emergency situation prevented us from obtaining acknowledgement.

Other (Please Specify)

_____