ALINE BOWERS, D.D.S

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement

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

Please Print Name: _____

Signature: _____

Date: _____

ALINE BOWERS, D.D.S.
FAMILY RELEASE FORM

Patient's Name: _____ Date of Birth: _____
While under the care of Aline Bowers, D.D.S., I hereby give authorization for the release of health related information to the following family members and/or appointed individual.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

This information may be given to the above - mentioned people either by phone, fax or in person should the need arise for this information to be released for my proper care while a patient here. Should any unforeseen incident arise that I wish not to inform any or all of the above named people, I will notify Aline Bowers, D.D.S., in writing of such names

_____ _____
Patient's Name Date

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

□ Communications barriers prohibited the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please Specify) _____

Employee Name **Date**