ACKNOWLEDGEMENT OF RECEIPT
OF PRIVACY POLICY NOTICE

I _____, acknowledge that the privacy policy
(Patient if 18 years old, representative if under 18 years old)
for the office of Dr. Douglas B. Evans, DDS, MS of Rocky Mountain Prosthetic Dentistry, PC, has been made available to me for review. I understand that I may request a copy of this privacy policy.

_____ _____
Patient Signature or Patient Representative (Parent) **Date**

In case you do not agree to sign this form, our office must indicate why you decline to do so.
Reason for patient's refusal:

_____

_____

_____ _____
Privacy Director's Signature **Date**

Medical Release Form

This portion is optional. Due to the federal regulations regarding patient privacy, our office is restricted from releasing any information to individuals other than the patient directly if the patient is 18 years old or older. This includes billing information, treatment information, appointments, etc. If you would like our office to release any information to anybody other than yourself (i.e. spouse, parent, attorney, etc), we ask that this portion be completed. Do NOT list other physicians and/or dentists.

I _____ hereby give permission to the office of Dr. Douglas B. Evans, DDS, MS to release the following information to the person(s) listed below:

(Please Check only 1 of the following)

_____Billing information only

_____Treatment information only

_____All information including billing and treatment information

to: _____, _____
Name of person **Relationship to patient**

List Additional persons and their relationship here:
_____

This authorization shall expire on _____/_____/20_____ (A physical date is required and may be up to 50 years from this date). I may elect to terminate this authorization at anytime by submitting written consent to terminate.

_____
Print Patient Name

_____ _____
Signature Patient Name **Date**