HIPAA
Acknowledgement of Receipt of Notice of Privacy Practices

*****You May Refuse to Sign this Acknowledgment

Patient
Name_____

I,

_____
(parent/legal guardian name)

have received a copy of the Linn County Dental Coalition – Dental Clinic at the Boys & Girls Club of Albany Notice of Privacy Practices.

Parent/legal guardian signature
_____Date_____

**For Office Use only: ***We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because: __Individual refused to sign, __Communications barriers prohibited obtaining the acknowledgment, ___ An emergency situation prevented us from obtaining acknowledgment, __Other (Please Specify)

Authorization of Release of Protected Health Information

By signing this document, you are allowing the Linn County Dental Coalition – Dental Clinic at the Boys & Girls of Albany staff to give or receive from other health care providers or child agencies your child's health care records to provide the best care for your child. The records may be sent to another dentist, dental specialist or other health care provider that the Dental Clinic staff recommends further treat your child. The information may also be shared with an agency that your child is affiliated with (such as school, Head Start, etc.) for record keeping purposes.

Patient's Name _____

I hereby authorize:
Linn County Dental Coalition – Dental Clinic at the Boys & Girls Club of Albany
to receive from or release to the appropriate health care provider or agency, my child's records to facilitate his or her health care needs and/or treatments.

Name of parent/legal
guardian_____
(please print)

Parent/legal guardian signature_____Date_____

If there are providers or agencies that you do NOT want your child's records released to or received from please list here:

_____ _____