Sara Wolfe D.D.S., M.S.D

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____, am aware that there is a copy of the Notice of Privacy Practices posted in the reception area of Dr. Sara Wolfe's offices. I understand that I am entitled to a paper copy upon request.

Protected health information disclosure:

( ) I decline to sign the Acknowledgement

Please *print* your name: _____

Please *sign* and *date*: _____

Release of Records

Please list below any person or physician that has permission to access any information pertaining to the patient.

1. Name_____ Relationship to Patient _____

2. Name_____ Relationship to Patient _____

3. Name_____ Relationship to Patient _____

If you would like a password for Release of Records please note one:_____
Please notify everyone listed above with the password. Patient's date of birth will also be needed for verification.

Permissions:

☐ I consent to detailed messages, including but not limited to account information, patient information, and appointment information being left on any of my answering systems (cell phones, emails etc.) that I have provided to Dr. Wolfe's office.

☐ I only consent to patient's appointment reminders to be left on any of the above mentioned answering systems.

☐ I do NOT consent to any messages.

☐ I give permission for Dr. Wolfe's office to file my insurance for all charges necessary.

Patient Name: _____

Responsible Party Signature: _____Date: _____