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CLARK ORTHODONTICS
ANDREW E. CLARK DMD, MS

HIPAA Acknowledgement and Medical Information Release Form

By signing this form, you acknowledge that you have read and understood our Notice of Privacy Practices. If you would like a copy, please ask your front desk coordinator.

Patient Name: _____ Date of Birth: _____/_____/_____

Responsible Party Name (if different): _____

Release of Information

- ☐ I authorize the release of information including the diagnosis, records, examination results, claims information and financial information. This information may be released to:

  _____

- ☐ Information is not to be released to the following:

  _____

- ☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated in writing.

Messages

Please call _____my home _____my work _____my cell Number: _____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ Please do not leave a message

The best time to reach me is (day)_____ between (time)_____

Media Release

Occasionally you or your child may be photographed in our office, as winners of contests or at office events. These photographs may be used in several different ways including social media, website, etc. Please select one of the below:

- ☐ I give permission for photos of myself or my child to be used, along with my name or my child's name
- ☐ I give permission for only the photos to be used but not my name or my child's name
- ☐ I do not give permission for any photos or names to be used

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____