Acknowledgement of Receipt of Notice of Privacy Practices

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices. (Page 1 of 2)

Print Name:____

Signature:____

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 obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

---

31 Bailey Ave Suite C
Ridgefield, CT. (203) 431-3901
HOMETOWN DENTAL

HIPAA Authorization Form for Family Members and Friends

I,____, grant permission to Dr. Nicholas Ritzcovan to disclose and release my protected health information (PHI) to the following persons:

Name (s): Relationship:

___________________________________ ___________________________________

___________________________________ ___________________________________

Health Information to be disclosed:

- o My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions dental and/or medical related)

OR My complete heath record, as above, **with the exception** of the following information: (Check as appropriate):

- o Mental health records
- o Communicable diseases (including HIV and AIDS)
- o All dental records
- o Other (please specify):

____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (check one):

- o All past, present, and future periods,
- o **OR** Until date or event:____
  unless I revoke it. (NOTE: You may revoke this authorization at any time by notifying us in writing.)

____

Printed Name of the Person Giving this Authorization

____ _________________________

Signature of the Person Giving this Authorization Date