Chris D. Kinney, D.D.S.
3825 Fairview Dr. Anderson, IN 46013

acknowledgement of availability of notice of privacy practices

You may refuse to sign this acknowledgement

I, _____, have been informed of the availability of this office's Notice of Privacy Practices. I understand that free copies are available in the reception area and that a copy is posted in the reception area should I wish to read it there.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of availability 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)

_____
_____
_____

Staff Signature _____

PLEASE COMPLETE REVERSE SIDE

Chris D. Kinney, D.D.S.
3825 Fairview Dr. Anderson, IN 46013

Authorization to Release Health Care Information

Patient's name: _____ Date of birth: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me (to the recipients listed below) as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations. I know that Dr. Chris D. Kinney, DDS will have no control over the information re-disclosed by the recipient.

Note: Recipients are required to show proof of their identity prior to the release of any information.

Recipient(s):

Name: _____ Relationship: _____ Address: _____

Name: _____ Relationship: _____ Address: _____

OR: NONE: _____ (Do not release information to anyone)

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment: _____

THIS AUTHORIZATION IS TO EXPIRE ON: _____.

I may cancel this authorization at any time by notifying Chris D. Kinney, DDS in writing. If I choose to do so, my revocation will not affect any actions taken by Chris D. Kinney, DDS before receiving my revocation.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

_____

Signature of patient or patient's authorized representative Date signed

_____

Relationship or status if signed by parent, legal guardian, personal representative, etc.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. THIS CONSENT IS TO BE INCLUDED IN THE PATIENT'S CHART AFTER IT HAS BEEN COMPLETED

PLEASE SEE COMPLETE REVERSE SIDE

For office use only: Copy of signed authorization provided to the individual

Date: _____ Initials: _____