rockypointdental
MICHAEL BRIAN BUSH, DMD, PA

ACKNOWLEDGEMENT OF OFFICE POLICY REGARDING PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

I, ______________________________ have received and/or been
Patient/Parent or Guardian Signature
offered a copy of Michael Brian Bush, DMD PA (Rocky Point Dental) notice of privacy practices. I authorize Rocky Point Dental to release my dental and billing information to the following individual(s):

1. ____________________ Relation to Patient: ______________
2. ____________________ Relation to Patient: ______________

Print Patient Name: ______________________________________

Print Parent/Guardian's Name (if patient is a minor): __________________

Date _______________________

****YOU MAY REFUSE TO SIGN THIS DOCUMENT****

Form not signed due to:

___ Patient refusal
___ Communication barrier prohibiting acknowledgement
___ Emergency situation preventing acknowledgement
___ Other (Please specify)

Staff Member ____________________ Date____________________