

Dr. Brian Brumbaugh and Dr. Mark Shaw
15 Gosnell Crossing
Staunton, VA 24401

Notice of Privacy Practices Acknowledgement

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. You may refuse to sign this acknowledgement.

I, _____, have received or been offered a Notice of Privacy Practices for the office of Brian Brumbaugh, D.D.S. and Mark Shaw, D.M.D.

Patient(s) Name

Signature Parent/Guardian

Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding your child covered under the Privacy Act to people other than yourself.

Patient(s) Name

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding my child/children. (Please list all persons who may bring your child to an appointment, schedule or change an appointment time, or listen to information regarding your child's dental care or treatment),

Print Name

Relationship to Child

Telephone Number

Print Name

Relationship to Child

Telephone Number

Print Name

Relationship to Child

Telephone Number

Parent/Guardian Signature: _____ Date: _____