Dr. Brian T. Brumbaugh DDS

Pediatric Dentistry

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 T. Brumbaugh. D.D.S.,P.C.

_____

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: _____