



Information Release

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION OF PAYMENT OF BENEFITS

Acknowledgement of Receipt of Notice of Privacy Practices *You May Refuse to Sign This Acknowledgement.*

I have received a copy of this office's Notice of Privacy Practices.

Please 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
- Communication barriers prohibited obtaining acknowledgement
- Emergency prevented obtaining acknowledgement
- Other (please specify): _____

Authorization to Release Information and Authorization of Payment of Benefits

I hereby authorize Mariana Conant, DDS, LLC to provide any insurance company(s), claim administrator(s) and consulting healthcare professional(s), information concerning health care advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administering claims for benefits. I further authorize payment directly to Mariana Conant, DDS, LLC of the dental benefits otherwise payable to me. I agree that a photocopy of this authorization is as valid as the original.

Signature: _____ Date: _____

(If patient is a minor, Parent or Guardian must sign here)