**Eric and Casey Burns, DDS**
**4914 Randall Parkway**
**Wilmington, NC 28403**
**910-799-9059**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**
**WRITTEN ACKNOWLEDGEMENT FORM**

I have read and been offered a copy of **Eric and Casey Burns, DDS** Notice of Privacy.

___________________________ ___________________________
**Patient Name** **Date of Birth**

___________________________ ___________________________
**Signature of Patient** **Date**

## Emergency Contact Information

**Name**: _______________________________________ **Relationship to Patient:** __________________________

**Phone**: ______________________________________ **Address**: _______________________________________

**COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION**

**Eric and Casey Burns DDS** is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

| **Entity to Receive Information**<br>Check each person/entity approved<br>To receive information | **Description of information to be released**<br>Check items that may be provided the<br>person/entity on the left | |
|---|---|---|
| Voice Mail | Results of lab tests/x-rays | |
| Employer/School | Appointment absentee information | |
| Spouse (provide name) | Financial | |
| | Medical | |
| Parent (provide name) | Financial | |
| | Medical | |
| Other (provide name) | Financial | |
| | Medical | |
| Support Group (provide name) | Demographic Information | |

**Rights of the Patient**: I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Eric and Casey Burns DDS**.I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient. Written notification will be sent via first class mail for any breach involving over 500 patients per HIPAA regulations.

___________________________________ ______________________________
Signature of Patient Date