JASON DAABOUL, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO RELEASE INFORMATION

****You May Refuse to Sign This Acknowledgement****

Patient Name: _____

Guardian Name (if Minor): _____

I have been provided and have reviewed the Notice of Privacy Practices of this office. I understand that my dental records are confidential and cannot be disclosed without my prior authorization.

I give my permission for Dr. Jason Daaboul and/or their employees to contact me at the following numbers in order of preference. If necessary, messages can be left at the numbers indicated by a checkmark. I also agree to receive email messages at the email listed below.

Phone Number	Location (Home, Work Cell, Etc)	OK to Leave Message	
1.			
2.			
3.			
4.			
Email		**Email Address:**	

Dr. Daaboul and/or their employees have my permission to release dental and/or financial information to the following individuals:

Person: _____ Relationship:_____

Cell Phone #:_____ Home #: _____

I permit release of : ∈ Dental Information ∈ Financial Information

Person: _____ Relationship:_____

Cell Phone #:_____ Home #: _____

I permit release of : ∈ Dental Information ∈ Financial Information

I understand I have the right to revoke this authorization at any time and that my revocation must be in writing. I am aware my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have already acted in reliance upon this authorization.

Patient's (Or Guardian) Signature_____ Date _____