BURKHART DENTISTRY
4005 Spicewood Springs Rd. Suite A-100 – Austin, Texas 78759
(512)499-0212 – (512)499-0619 Fax – info@burkhartdentistry.com - www.burkhartdentistry.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement but, in refusing we will not be allowed to process your insurance claims.

On this date _____, the undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **BILL BURKHART, DDS**. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT AND BILLING INFORMATION** VIA:

- □ Cell Phone Confirmation
- □ Home Phone Confirmation
- □ Work Phone Confirmation
- □ Text Message to my Cell Phone
- □ Email Confirmation
- □ U. S. Mail / Postcard

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** BE CONVEYED VIA:

- □ Message on Cell Phone
- □ Message on Home Phone
- □ Message on Work Phone
- □ Text Message
- □ Email Message
- □ U. S. Mail / Postcard
- □ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW DENTAL INFO** VIA:

- □ Phone Message
- □ Text Message
- □ Email
- □ U. S. Mail / Postcard
- □ **Any of the above**

Office Use Only

Privacy Officer attempted to obtain patient's or representative's signature of Acknowledgement but unable because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____
Signature of Privacy Officer