All Smiles Dental Authorization Form

I understand that Maine law protects the privacy of patients. Generally, my doctor needs my written consent in order to release health care information about to others outside my doctor's office. I understand though that disclosure may be in some situations help me to get proper care and may be necessary for my doctor to bill insurances and other sources of payment for my care.

I consent to my doctor(s) giving healthcare information about me to other in situations listed below. This healthcare information may include parts of my medical record and other information about my medical condition, history or treatment.

Authorization of Medical benefits to Dr. Peter J. Garramore DMD:
I hereby authorize payment directly to Peter J. Garramore DMD.

____ ___________________
Patient/Parent signature Date

Authorization for Release of Medical Information:
I hereby authorize All Smiles Dental to release any information necessary to process my medical and/or dental claim.

____ ___________________
Patient/Parent signature Date

Authorization Regarding Patient Confidentiality:
I hereby authorize the staff of All Smiles Dental to: (initial all lines that apply)

_____ Leave a message with anyone answering my telephone at my residence, or any provided number, as well as, my answering machine/voicemail concerning appointment information or need to contact All Smiles Dental.

_____ Leave a message at my place of employment concerning an appointment or need to contact All Smiles Dental.

_____ Discuss test results or plan of treatment with my physician, parent and/or family members. If yes, please specify individuals:____

_____ Do not disclose any information concerning: ____

_____ Healthcare information about me may be given to or obtained from healthcare workers or facilities outside my doctor's office in order to provide proper care for me.

_____ Discuss billing issues with a parent, spouse, domestic partner and/or family member. If yes, please specify: ____

_____ Initiate treatment for my child/legal dependant in my absence. Healthcare information about my child/ dependant may be given to or obtained from healthcare workers or facilities outside my doctor's office in order to provide proper care for my child/ dependant.

My consent to release records is effective until I request to make changes to this form or the form is altered by All Smiles Dental. I understand that I can change this authorization with written notice at any time.

Patient/Parent/Legal Guardian Signature and Date____

Print Patient Name____

All Smiles Dental

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse To Sign This Acknowledgement****

I,______________________________, have had the opportunity to read this office's Notice of Privacy Practices, have asked any questions I had pertaining to this issue and have no further questions with regards to Privacy Practices.

Printed 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 the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (Please Specify)