First Impressions
Dentistry

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with First Impressions Dentistry's notice of Privacy Practice. This notice describes how my health information may be used and disclosed.

I also hereby authorize the release of any health information including digital radio graphs, other diagnostic information, or cost information to the following person/persons:

Release to:_____

Relationship to patient:_____

Patients printed name:_____Signature: _____

Date:_____

Permission to Use Photograph

I grant to First Impressions Dentistry, its representatives and employees the right to take photographs of me and my teeth. I authorize First Impressions Dentistry, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that First Impressions Dentistry may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, social media and Web content.

Patients Signature for photo:_____

If under 18-Parent or Guardians Signature:_____

Office use only
We attempted to obtain written acknowledgment of receipt of our notice of privacy practice, but could not obtain because:

__ Individual refused to sign
__ Communication barriers prohibited obtaining the acknowledgment
__ An emergency situation prevented us from obtaining acknowledgment
__ Other