Kraisinger Family Dentistry
Paul J. Kraisinger DMD, Joshua A. Parry DMD, and Associates
312 N. Chestnut Street
Scottdale, Pa 15683
724-887-7860

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

With my consent, Kraisinger Family Dentistry may use and disclose protected health information about me to carry out treatment, payment, and insurance authorizations and payment requests. Please refer to our Clinical Notice of Privacy Practices for a complete description of such uses and disclosures. Our practice provides this form to comply with the Health Information Portability and Accountability Act (HIPAA) of 1996.

Date : _____

I acknowledge that I was provided with a copy of Kraisinger Family Dentistry's Notice of Privacy Practice.

Patient Name (Print) _____

Patient Signature _____

If completed by a patient's personal representative (or if the patient is a minor), please print and sign your name in the space below.

Personal Representative/Guardian (Print) _____

Personal Representative/Guardian (Signature) _____

Relationship to Patient _____

If permission is granted to share your health and dental information with a family member(s), please list the name of the person below and your relationship :

_____

Name Relationship