Thomas R. Fordiani, DDS.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of

Thomas R. Fordiani, DDS Notice of Privacy Practices

Patient/Guardian Signature: _____Date: _____

Medical and Financial Information Authorization and Release

Many of our patients allow family members such as their spouse, parents or others to call and request dental or billing information. The HIPPA (Health Information Portability and Privacy Act) of 1996 was created with the sole purpose of protecting patient's medical records and financial information. If you wish to have your dental or billing information released to anyone, please sign this form and indicate below to whom we can share this information with.

Spouse: _____ Parent/Guardian: _____

Partner: _____ Other: _____

Authorization to Leave Detailed Messages

I authorize the staff of Thomas R. Fordiani, DDS to contact me by text, email, and/or leave voice messages containing dental and/or financial information at the following:

Home: _____ Cell: _____

Other: _____ Email: _____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information disclosed. I understand that information disclosed to any of the above recipient, text, voicemail or email in no longer protected by federal or state law and may be subject to redisclosure by the above recipient or someone who has access to your voicemail, email or text.

You have the right to revoke this consent in writing.

Patient/Guardian Signature: _____ Date: _____