

Partnership for Excellence, PLLC

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Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices. By signing this form, I confirm that I have received a copy of the Notice of Privacy Practices.

Patient Name: _____
(Print)

Responsible Party Name (if different from above): _____

Signature: _____ **Date:** _____

Authorization to Release Information

I hereby authorize Partnership for Excellence, PLLC to release and/or discuss information regarding my health, treatment, and/or account with the following individual(s):

1) Name: _____

Relationship: _____

2) Name: _____

Relationship: _____

3) Name: _____

Relationship: _____

4) No one: (check here)

Signature: _____ **Date:** _____

This authorization will remain in effect until Partnership for Excellence, PLLC is notified in writing of any changes