Anna Smiles
DENTAL CENTER
Pavani Inapuri, DMD

817 W White St, Suite 100, Anna, TX, 75409
Ph: (214) 631-9199 Fax: (877) 209-0956
info@annasmilesdental.com

PRIVACY NOTICE ACKNOWLEDGEMENT

To Our Patients:

Federal law requires that we provide you with a copy of our Privacy Notice.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the notice.

If you have questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officers is located in your copy of the Privacy Notice that is available on the website and in our office.

I, (please print your name)_____, **have received a copy of this office's Notice of Privacy Practices.**

Signature:_____

Date: _____

IF PATIENT IS UNABLE TO ACKNOWLEDGE RECEIPT, STAFF MEMBER PROVIDING NOTICE TO COMPLETE THIS SECTION
The Privacy Notice was provided to:

Patient Name:_____On this Date: _____

The patient was unable to acknowledge receipt of the Privacy Notice for the following reasons

_____

_____

_____

Staff Signature: _____

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AUTHORIZATION TO RELEASE DENTAL RECORDS

I hereby grant Anna Smiles Dental Center or my treating dentist permission to release ANY or ALL of my dental records to the persons identified below. I also understand that only digital copies of documents may be forwarded/transferred via email. I also authorize the below stated individuals to discuss ANY TREATMENT PLANS and MAKE PAYMENT arrangements on my behalf.

I understand that the above authorization is voluntarily given and may withdraw the authorization at any time for any individuals. I also understand that any such request must be in writing only. Verbal authorizations or any other form of authorization is not valid unless approved by Anna Smiles Dental Center.

Name: _____ Email: _____
Phone: _____ Relation: _____

Name: _____ Email: _____
Phone: _____ Relation: _____

Name: _____ Email: _____
Phone: _____ Relation: _____

_____ _____
Patient Signature (Parent if pt. is a minor) Date _____

_____
Patient Name (Please PRINT)