



139 Patrick Avenue  
Urbana, Ohio 43078  
937-653-8650

**HIPPA INDIVIDUAL ACKNOWLEDGEMENT OF  
PRIVACY PRACTICES & RELEASE FORM**

Patient's Name: \_\_\_\_\_

It is Champaign Dental Groups policy not to release any information, intentional or unintentional regarding any personal, medical or dental information without the expressed written consent of the patient and/or legal guardian.

Therefore by signing this form, I am providing written permission for Champaign Dental Group to leave messages regarding any dental appointments and/or treatment at any of the following three (3) phone numbers:

- 1. ( ) \_\_\_\_\_ H W Other ( ) \_\_\_\_\_
- 2. ( ) \_\_\_\_\_ H W Other ( ) \_\_\_\_\_
- 3. ( ) \_\_\_\_\_ H W Other ( ) \_\_\_\_\_

I understand by signing this consent I authorize you to use and disclose my protected health information to carry out:

- > Treatment (including direct or indirect treatment by other healthcare providers involved with my treatment)
- > Obtaining Payment from third party payers (e.g. my insurance company)
- > Day to day healthcare operations of your practice.

In addition, also by my aforementioned signature I am providing written permission for Champaign Dental Group to discuss or release information regarding my dental care and/or appointments to the following individuals:

- 1. \_\_\_\_\_ relationship to patient \_\_\_\_\_
- 2. \_\_\_\_\_ relationship to patient \_\_\_\_\_
- 3. \_\_\_\_\_ relationship to patient \_\_\_\_\_

We appreciate the trust you have given us and are dedicated in providing you the most comprehensive, modern, safe and caring treatment possible!

By my signature I agree to all assignments and policies stated herein.

\_\_\_\_\_  
Patient/Legal Guardian

\_\_\_\_\_  
Witness