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