



Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Date

Print Name

Signature

Authorization for Release of Medical Information

I have been presented with a copy of Dr. Gotun's Notice of Privacy Policies that provides, in detail, how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I hereby authorize Dr. Tor Gotun, DDS or his agent or staff to release any of my personal medical information to the following individuals:

By not listing anyone on the lines above, I understand that none of my personal medical information will be discussed with or distributed via phone, fax, email, or mail to anyone other than myself. _____(initial)

For Our Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

- Patient refused to sign
- Communication barriers prevented us from obtaining acknowledgement
- An emergency prevented us from obtaining acknowledgement
- Other (Describe below)

