Bitterroot Valley Dental Care
120 LJK Way, Stevensville, MT 59870
(406)777-5070

Print name:_____

Acknowledgement of Receipt of the HIPAA Notice of Privacy Practices

I have been offered a copy of the Notice of Privacy Practices for Bitterroot Valley Dental Care.
I understand that a copy of the notice is posted in office, online, and available if I have any questions.

Medical Information Release (Check one box)

☐ Do Not release information to anyone other than the patient.

☐ I authorize the release of information including diagnosis, treatment plan, appointment information and claims information. This information may be released to:

Name:_____ Relationship to patient:_____

Name:_____ Relationship to patient:_____

Name:_____ Relationship to patient:_____

This release of information will remain in effect until terminated in writing by the patient.

Signature:_____ Date:_____

For office use only

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify)_____