

Lakeview Dental Clinic

603 Bemidji Ave
Bemidji, MN 56601
218.751.4523

Notice of Privacy Practices

Patient Name: _____

Date: _____

I acknowledge that I have received the Lakeview Dental Clinic notice of Privacy Practices that describes how my dental and medical information may be used or disclosed as required by federal law.

Signature of Patient, Parent or Guardian

Print Name

Permission to Discuss Dental Information

The privacy of your dental and medical information is very important to us. If you wish us to discuss information about your medical condition to your family, friends, caregivers, or others, please indicate this by completing the information below.

I _____ (Patient or Guardian Name)

permit the discussion of (print patient's name) _____ healthcare information for the purpose of communicating results, findings, care decisions and billing/payment information to the following individuals:

Name

Relationship

Name

Relationship

I understand that dental practice personnel will use their professional judgment to determine if the discussion is in my best interest if I am not present, incapacitated or in an emergency situation and that this authorization will remain in effect until revoked by me in writing.

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- _____ Individual refused to sign
- _____ Communication barriers prohibited obtaining acknowledgement
- _____ An emergency situation prevented us from obtaining acknowledgement
- _____ Other _____