**DR. MARC A. COHEN**

**5356 Estate Office Drive, Suite 1**

**Memphis, TN 38119**

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES Notice**

I have received a copy of this office’s Notice of Privacy Practices and I understand that I have the right to revoke this authorization at any time and the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any other recipient is no longer protected by federal or state law and may be subject to redisclosure by the patient. I understand that I have the right to revoke this consent in writing.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a personal representative signs this authorization on behalf of the patient, complete the following:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgment for Release of Information**

Many of our patients allow family members such as their spouse, parents, or others to call and request dental or billing information. Under the requirements of HIPAA, we need patient’s signature on this form for consent to release dental or billing information. Signing this form will give information to only those people indicated below. I authorize Dr. Marc A. Cohen to release my dental and/or billing information to the following individual(s):

1. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the **release of information** will remain in effect until terminated in writing.

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_