Westmoreland Dental Group
Family • TMJ-Migraine • Sedation

# ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES FOR THE OFFICE OF DR. J.D. WESTMORELAND

Patient Name _____ DOB:_____

1. I have received a copy of the Notice of Privacy Practices, including the Updated Notice of Privacy Practices effective September 23,2013, from the office for either myself or my child who is the patient.
2. I hereby authorize this office to release, disclose and/or discuss any or all information regarding my office visits, diagnosis and medical care to the following individuals (example: wife, husband, son, daughter, sister, brother or any other person you may feel needs to know). ***If no names are listed you, the patient or guardian, will be the only person we are able to talk to via phone or in person.***

   _____ _____

   _____ _____

3. I hereby authorize this office to leave a message on my answering machine/voicemail or with anyone who may answer my phone, identifying himself or herself as being from this office to either confirm an appointment or to call the office back.

   **YES** **NO**

   **Cell phone # for Confirmation Texts** _____

   **Signature** _____ **Date**_____

   **Witness** _____ **Date**_____

The above signature will apply to all areas that have been filled in with information by I, the patient or a representative that I, the patient, have chosen to assist me in filling out my paperwork. **PARENTS ARE RESPONSIBLE FOR CHILDREN UNDER THE AGE OF 18.**

I understand that I may revoke this authorization by sending a written notice to the office. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

If you have any questions regarding patient rights, please request to speak to our staff. You have the right to speak with an attorney or other counsel prior to signing. We have no control over information once you have authorized its release from our office.