Central Virginia Dental Care, PLC

David C. Circeo, DDS

6113 Lakeside Ave.
Richmond, VA 23228

HIPAA Written Acknowledgement Form

Patient Name: _____ Date_____

Our Notice of Health Information Practices provides information about how we may use and disclose PHI (Protected Health Information) about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have received a copy of the Notice of Health Information Practices.

I have had an opportunity to read the Notice of Health Information Practices.

I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Health Information Practices.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

_____ _____
Print Name of Patient, Parent, or Legal Guardian Relationship to patient Date

Medical Information Release Form

Do you authorize our office personnel to discuss your medical information with anyone else?

☐ **No** ☐ **Yes**

_____ _____ _____
Name Relationship to Patient Phone Number

_____ _____ _____
Name Relationship to Patient Phone Number

Preferred Phone Number _____