9405 Illinois Road
Fort Wayne, IN 46804

James P. Klinger, DDS
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ACKNOWLEDGEMENT FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received (or was offered but declined) a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE INFORMATION

The following people have my permission to obtain information that is protected by the HIPAA Privacy Notice:

Please print: _____

Please print: _____

Please print: _____

Please print: _____
(for additional lines please use back of form)

_____ I do not allow anyone access to my information.

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AUTHORIZATION TO RELEASE/OBTAIN X-RAYS

I authorize Klinger Family Dental to obtain and/or release my x-rays from/to a previous or new dental provider.

Signature: _____ Date: _____