Mark E. Grubb DDS

NORTHEAST ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, P.A.

PERMISSION FOR OTHER THAN THE PATIENT / GUARDIAN OF RECORD
TO RECEIVE PATIENT'S TREATMENT, BILLING AND APPOINTMENT INFORMATION

NAME OF THE PATIENT: ____DOB:___________

I, ____ **as (Patient/Parent or Guardian)**
(Please Print)

am giving Northeast Oral & Maxillofacial Surgery Associates PA, permission to release treatment, billing and appointment information about services provided for the above named patient to:

(Please Print)

Name:	Phone Number	Relationship to Patient
Name:	Phone Number	Relationship to Patient
Name:	Phone Number	Relationship to Patient

These individual(s) may bring this patient in for dental surgery. In addition, these individual(s) will be able to make future appointments for treatment if needed,

Signed: ______________________________________

Date: ____

Please Complete Reverse Side

NORTHEAST ORAL & MAXILLOFACIAL SUGERY ASSOCIATES, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

Effective Date October 2013

I, ____, hereby acknowledge that I have received
(please print name)

copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions

I may have regarding this Notice.

____ ________________________
(Signature) (Date)

For Office Use Only

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

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevents us from obtaining acknowledgment

☐ Other (Please Specify) ____

Please Complete Reverse Side