ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES FOR OFFICE OF DR. C. STANLEY MITCHELL, JR. DDS

A. I prefer to be contacted regarding treatment, financial concerns and appointments via: (Please check all that apply)

( ) HOME PHONE:_____

( ) CELL PHONE:_____

WOULD YOU ALLOW TEXT MESSAGES? YES NO

( ) WORK PHONE:_____

B. EMAIL ADDRESS:_____

C. I authorize the following persons to receive any information regarding my appointments, financial transactions, and treatment:

1. Name:_____

   Phone:_____

   Relationship to patient:_____

2. Name:_____

   Phone:_____

   Relationship to patient:_____

D. If Patient(s) (is/are) a minor (under the age of 18), please indicate names:

1._____

2._____

3._____

PATIENT ACKNOWLEDGEMENT:
I acknowledge that I have read and been offered a copy of this information, and am aware of my rights as a patient with regard to HIPAA regulations and my PHI (Personal Health Information).

Name:_____Date:_____