ADVANCED ENDODONTIC GROUP

Consent for Release of Medical Records and Information

I, _____, (hereafter "Patient") hereby authorize Ingrid Epelman Dorra, DDS and Advanced Endodontic Group, Inc., (hereafter collectively referred to as "Practice") to use and disclose the entire medical record concerning Patient in accordance with the attached Notice of Privacy Practices (NOPP). I have received a copy of and reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release and hold Practice, its employees and agents harmless from any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

Patient _____ Date _____
(Print name and sign)

Or

By Patient's Representative _____ Date _____
(Print name, sign, and describe authority)

Acknowledgment of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Advanced Endodontic Group this _____ day of _____ , 20____ . A copy of this signed, date Acknowledgement shall be effective as the original.

_____
Please print your name

_____
Please sign your name

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority.

_____

Office Use Only
As Privacy Official, I attempted to obtain the patient's (or representative's) signature on the Acknowledgment, but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign
- ☐ Because (Please describe)

_____
Signature of privacy official