Richard W. Van Gurp, DDS, PA

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name : ____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_________________________________ ___________________
Signature Date

Authorization for Release of Information to Family and/or Friends

This office is authorized to release protected health information about the above named patient to the entities named below:

_____ Leave information on the voice mail. _____ Give information to spouse.
_____ Give information to the following persons: _______________________

Information to be released:

_____ Financial Information _____ Information result from test or x-rays.
_____ Medical Information
_____ Other information as described: ______________________________

Statements will list family activity unless otherwise directed.

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Dr. Richard W. Van Gurp, 3111 Springbank Lane, Suite F, Charlotte, NC 28226. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_________________________________ Date ___________
Signature of Patient or Personal Representative

C: Acknowledgement of Receipt Revised 1.2007