ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You may refuse to sign this acknowledgement ****

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify)

_____

_____

X-RAY AND TREATMENT PHOTOS RELEASE FORM

Treatment related photography and x-rays taken during treatment can be used for various reasons, such as: presenting treatment to a patient, treatment discussion with other Doctors, dental lab use if your case requires it, before and after pictures on our digital and print media channels, to be a part of your permanent record and for educational purposes.
I hereby grant Smile Dental Center permission to reproduce, publish, print, use and distribute copies of such photographs and/or x-rays as seen fit.

NO FULL-FACE OR IDENTIFYING TREATMENT RELATED PHOTOS WILL BE USED IF YOU SIGN THIS PART OF THE FORM.

I hereby hold harmless, release, and forever discharge SDC from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHOTO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW. I ACCEPT:

Print Name: _____

Signature: _____ | Date: _____ / _____ / _____

If under 18 years old:

Parent/Guardian Signature: _____ | Date: _____ / _____ / _____