Rocky Mountain Dental Group
www.RockyMountainDentalGroup.com
(303)233-1335 • 2475 Wadsworth Blvd, Lakewood, CO 80214

Acknowledgement of Receipt of Privacy Practices And Consent/Limited Authorization & Release Form

You may refuse to sign this acknowledgement but, in refusing,
we will not be allowed to process your insurance claims

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Rocky Mountain Dental Group. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.

Patient Full Legal Name: _____

1. What name I prefer to be called: _____
2. How I like to get routine messages: (Please check all that apply)
   Letter_____Email_____Phone_____Fax_____
3. It is ok to leave a message about my dental health: (Check all that apply

   Never_____
   Home_____ Number: _____
   Cell _____ Number: _____
   Work _____ Number: _____
   Email_____ Email Address: _____
4. Please list any other parties who can have access to your dental information

   No One _____

   Name: _____ Relationship: _____ Phone: _____
   Name: _____ Relationship: _____ Phone: _____
   Name: _____ Relationship: _____ Phone: _____

_____ _____
Signature of Patient or Authorized Representative Date

Verification of Photo ID _____ Verified By: _____