KEVIN F. KINGRY, DMD, P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME: ______________________________________ **D.O.B.** ___________________

I have been made aware of the office's Notice of Privacy Practices.
(Copy is available upon request.)

SIGNATURE: ____ **DATE** ____________________

Release of Medical Information

I authorize the release of medical information including diagnoses, records, examinations, charges, claims, etc. rendered to me/my child to anyone listed below.
*SPOUSES AND PERSON FINANCIALLY RESPONSIBLE ARE NOT AUTOMATICALLY INCLUDED.

Name	Relationship
1. ____________________________________	______________________
2. ____________________________________	______________________
3. ____________________________________	______________________
4. ____________________________________	______________________

This Release of information will remain in effect until terminated by me in writing.

Signature: __________________________________ **Date:** ________________