Auburn Oral Surgery

390 Southbridge St

Auburn MA 01501

AUBURN ORAL SURGERY & IMPLANT CENTER

ACKNOWLEDGEMENT OF RECIEPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this dental practice HIPPA notice of privacy practices

AND

This signature on file is my authorization for the release of any medical information / records required by Dr Laith Azzouni to obtain clearance for my surgical procedure done at AUBURN ORAL SURGERY.

____________________________ Patient Name (Please print)

____________________________ Patient Signature DATE____________________

Authority of personal representative to sign for patient (Check One)

- ☐ Parent
- ☐ Guardian
- ☐ Power of attorney
- ☐ Other __________________

PLEASE NOTE IT IS YOUR RIGHT TO REFUSE TO SIGN THE ACKNOWLEDGEMENT