# Pompano Beach Periodontics

Practice Limited to Periodontics and Dental Implants

Jason Witonsky D.M.D., M.S

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY (HIPPA)

**The undersigned acknowledges the receipt of or copy made available of the currently effective Notice of Privacy Practices for Pompano Beach Periodontics this _____ day of _____, 20____. A copy of this signed and dated Acknowledgement shall be as effective as the original. The original Notice of Privacy Practices is located in our waiting room available for your reading purposes.**

_____ _____

**Print Name** **Signature**

**If you are the legal representative, legal guardian, or next of kin of patient, please print your name, the patient's name, and describe your authority.**

_____

**Thank you. If you have any questions about this form, please contact our Office Manager.**

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## AUTHORIZATION FOR INTEROFFICE COMMUNICATION

**For the patient, named below, I hereby authorize the office of Dr. Jason Witonsky to release medical information, dental history, x-rays, and any other health information that may be used for proper diagnosis and treatment to the referring or treating physician and/or dentist as needed to administer appropriate treatment/care.**

**Dental and health records may be mailed, faxed, or electronically transmitted. I allow release of these records for proper treatment.**

_____ _____

**Signature (Patient/Legal Guardian)** **Date**

_____

**Print Name**

**Refusal to disclose all or some healthcare information may result in improper diagnosis or treatment and/or denial of coverage for health benefits or other adverse consequences.**

2231 Northeast 25th Avenue, Suite 4 . Pompano Beach, FL 33062
Phone: 954-782-7911 Fax: 954-782-7925
www.pompanobeachperiodontics.com / Email: dr@pompanobeachperiodontics.com