WILLIAM B. HAMEL III, D.D.S.

========== *Comprehensive Dentistry* ==========

210 Burlington Avenue, Clarendon Hills, IL 60514 (630) 323-0380
Fax (630) 323-0522 E-mail - DrWBH@hotmail.com

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been offered/received a copy of the W.B. Hamel III, D.D.S., P.C. Notice of Privacy Practices.

Patient Name: _____ Date Of Birth: _____

Signature: _____ _____ Date: _____
Patient/Parent/Guardian

OFFICE USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Signature: _____ _____ Date: _____

Reason: _____ _____

PLEASE FILL OUT REVERSE SIDE AS WELL

WILLIAM B. HAMEL III, D.D.S.

========== *Comprehensive Dentistry* ==========

210 Burlington Avenue, Clarendon Hills, IL 60514 (630) 323-0380
Fax (630) 323-0522 E-mail - DrWBH@hotmail.com

DISCLOSURE TO FAMILY OR FOR NOTIFICATION

The purpose of this form is to identify the family members or other persons to whom we may disclose protected health and/or financial account information about you or notify regarding your care.

Patient Name: _____ Date Of Birth: _____

☐ **I authorize the following individuals to access or discuss my private medical and personal information:**

1) _____
NAME RELATIONSHIP

2) _____
NAME RELATIONSHIP

3) _____
NAME RELATIONSHIP

4) _____
NAME RELATIONSHIP

☐ **I do NOT give anyone authorization to access or discuss my private medical and personal information.**

_____ _____
Patient/Parent/Guardian Signature Date

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL YOU PROVIDE FURTHER NOTICE