Majestic Dentistry of Gastonia- Manish Sheladia, DMD Acknowledgement of Receipt Of Notice of Privacy Practices Patient Name & Address: I have received a copy of the Notice of Privacy Practices for the above named practice. Signature Date For Office Use Only We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because: An emergency existed & a signature was not possible at the time. The individual refused to sign. A copy was mailed with a request for a signature by return mail. Unable to communicate with the patient for the following reason: Other: Prepared By _____ Signature Date

Majestic Dentistry of Gastonia Authorization for Release of Information — Compound Release

| Name of Patient Maintain Statistics S | Norma + C D | |
|--|---|---|
| Entity to Receive Information. Check each person/entity that you approve to receive information of information to be released. Check each characteristic of the same section. Description of information to be released. Check each that can be given to person/entity on the fell in the same section. Worce Mail Spouse (provide name and phone number) Financial Medical Parent (provide name and phone number) Financial Medical Financial Medical In order for email communication to occur, please accept the disclosure below: Communication about treatment alternatives even if this office is being compensated for making the communication. Patient Rights: I have the right to revoke this authorization at any time. Revocation is not effective in cases where the information may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing on May no longer be protected by federal or state law. | | Date of Birth |
| Entity to Receive Information. Check each person/entity that you approve to receive information. Check each person/entity that you approve to receive information. Voice Mail | - Shelan | |
| Entity to Receive Information. Check each person/entity that you approve to receive information. Check each person/entity that you approve to receive information. Voice Mail | about the above named patient in the following manner and to identified persons | |
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| Voice Mail Voice Mail Results of lab tests/x-rays Other | Check each person/entity that you approve to | |
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| Email communication-Provide email address* | | |
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| In order for email communication to occur, please accept Breach notification For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication. Communication about treatment alternatives even if this office is being compensated for making the communication. Patient Rights: I have the right to revoke this authorization at any time. I may inspect or copy the protected health information to be disclosed as described in this document. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. | | La McCicai |
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| the information is released at the patient's request and this authorization will remain in effect until | | |
| revoked by the patient. | | |
| revoked by the patient. | | |
| Date | Cionnii | Date |
| Signature of Patient or Personal Representative Description of Personal Representative's Authority (attach necessary documentation) | | |
| Revised August 2013 | | |