The Fine Art of Family Dentistry
Lynn R. Wuthnow, DDS PA
1615 E Iron Ave
Salina, Kansas 67401

ACKNOWLEDGEMENT OF RECEIPT
I acknowledge that I viewed a copy of THE FINE ART OF FAMILY DENTISTRY PA Notice of Privacy Practices.

Patient name ____________________________________________
Signature _______________________________________________ Date _____________________

Permission to Disclose Information to Those Involved in My Care

I hereby allow the office of The Fine art of Family Dentistry, PA to disclose to the following people (because they are involved with my healthcare or payment):

____ Self/Parent
____ Spouse  Name:_____________________________________
____ Family or Friend  Name:_____________________________
____ Other  Name:_______________________________________

The following Protected Health Information:

____ Appointment times and dates
____ Test results (such as radiographic findings)

In the following forms of communication:

____ Home Telephone
____ Work Telephone
____ Cell phone
____ Email ________________________________
____ Other ________________________________

Patient or Guardian’s Signature ___________________________ Date ______________________