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