

RAVIN FAMILY DENTAL CARE



Authorization for Photography and Video Pictures You may refuse to sign this acknowledgement

I, _____, hereby consent that diagnostic photographs and / or video pictures can be taken of me by Daniel R. Ravin, P.C., or any authorized agent of Daniel R. Ravin, P.C. for any of the following purposes:

1. For inclusion in my dental records.
2. For any purposes of accreditation, illustration, publication in dental journals, internet / website information or for any other dental purpose deemed appropriate by my dentist. (Note: Information of these purposes will not be released without your verbal notification and consent.)
3. Law enforcement requests.
4. Educational purposes.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices “You May Refuse to Sign This Acknowledgement”

I, _____, have received a copy of this office’s Notice of Privacy Practices.

Printed Name: _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify): _____
