CONSENT FOR RELEASE OF MEDICAL RECORDS AND INFORMATION
&
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOUR SIGNATURE IS NECESSARY FOR US TO:

- **PROCESS ALL INSURANCE CLAIMS**
- **TO RELEASE MEDICAL INFORMATION TO INSURANCE COMPAINES**
- **HAVE ON FILE TO PROCESS CREDIT CARD PAYMENTS**
- **TO RELEASE INFORMATION TO OTHER MEDICAL/DENTAL PROVIDERS, WHEN NECESSARY, FOR YOUR TREATMENT**

I hereby authorize Thomas Lunstrum, DMD and Cocoa Village Dentistry, (hereafter collectively referred to as "Practice") to use and disclose the entire medical record concerning below indicated Patient in accordance with the attached Notice of Privacy Practices (NOPP). I have received a copy of and reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release and hold Practice, its employees and agents harmless from any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

Patient:
(**PRINT**)_____ (S**IGN**)_____ Date:_____

Office Use Only

I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment	____
I could not communicate with the patient	____
The patient refused to sign	____
The patient was unable to sign Because (please describe)	____

_____ _____
Staff Member – Print and Sign Name Date