

**SINHA FAMILY DENTISTRY**  
**Consent to Release Information**

Patients Name \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Yes \_\_\_\_\_ No \_\_\_\_\_ You may leave a message on my answering machine at my home/or cell phone

Yes \_\_\_\_\_ No \_\_\_\_\_ You may leave messages on my voice mail at work

Yes \_\_\_\_\_ No \_\_\_\_\_ You may send email to my email address

I understand that it is my responsibility to provide authorization to Pallavi Sinha, DMD, LLC.

In order to release any medical information regarding my care, I hereby authorize, Pallavi Sinha, DMD. LLC., to release medical information to the following: (i.e.- Spouse, significant other, parent)

\*If you do not list anyone, we CANNOT discuss your information with anyone.

\_\_\_\_\_

\_\_\_\_\_  
\*In addition, I authorize Pallavi Sinha, DMD, LLC and staff to discuss your medical/dental needs with your physicians and/or dental specialists, or your dental insurance company, in order to provide proper care.

\_\_\_\_\_ SIGNATURE

I, \_\_\_\_\_ understand that there may be a \$50 cancellation fee for appointments cancelled with less than 48 hour notice \_\_\_\_\_

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 for all who are in my household or under my insurance.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

Please return this document to :

Pallavi Sinha, DMD., LLC., 12486 Tesson Ferry Rd., St. Louis, MO 63128

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 acknowledgement

\_\_\_ An emergency situation prevented us from obtaining acknowledgement

\_\_\_ Other (Please specify)