Dr James G Rafael, DDSPA
RELEASE OF MEDICAL/DENTAL INFORMATION FORM

I, ______________________, having been informed of the HIPPA privacy policy, do hereby give authorization to the individual(s) listed below to have access to my confidential medical/dental information. This includes information concerning leaving messages about appointments at my home, billing and payments. I understand that I may revoke this authorization at anytime and will be required to do so in a written format that can be filed with this form.

Signature: ___________________________________ Date: __________________

Print Name: ____________________________________

List a minimum of two individuals below. Please print the full name

____

____

____

____

Acknowledgement of Receipt of Privacy Practices

I, ____________________________________ have received a copy of Dr. James G. Rafael's, DDSPA Notice of Privacy Practices with an effective date of February 23, 2003.

Name of Patient
Address Patient

Signature of Patient______________________________________**Date** __________

Name of witness

Signature of witness______________________________________ **Date** _________