Cynthia L. Nouri, DMD, PC
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 Dr. Cynthia Nouri, DMD P.C.
In order to release any medical information regarding my care. I hereby authorize Cynthia L. Nouri, DMD, PC, 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 Dr. Nouri 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 :
Dr Cynthia Nouri, 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)