

**Please sign both sections:**

**Acknowledgment of  
Notice of Privacy Practice**

By signing this document, I acknowledge that I have read a copy of the HIPPA  
Notice of Privacy Practices.

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



**RELEASE OF MEDICAL INFORMATION & AUTHORIZATION FOR TREATMENT**

I authorize the release of any medical information necessary to process a claim and further authorize payment of insurance benefits directly to Berland & McConnell MD, P.A. To provide for continuity of care, I authorize the release of medical information to specialty physicians who are participating in my care. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Berland & McConnell MDS, PA to perform procedures and treatment including the administration of medicine and local anesthetics along with other surgical and medical procedures that may be necessary.

Patient : \_\_\_\_\_

Date: \_\_\_\_\_

