NOTIFICATION AND AUTHORIZATION FOR USE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Your insurance company(s), third-party payors, other healthcare providers and persons you indicate to have access to your appointment, account or clinical treatment information.

   May we phone, email, or send a text to you to confirm appointments? YES NO
   May we leave a message on your answering machine at home or on your cell phone? YES NO

2. The purpose for the release is at the request of the individual.
3. There is no expiration date for this authorization unless specifically requested by the patient.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you are covered by a dental insurance plan, you will be required to file your own insurance claims as this office will not be able to release any information to them.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

PATIENT or Guardian Signature_____Date: _____

If you are signing as a personal representative or guardian of the patient, describe your relationship to the patient and/or the source of your authority to sign this form (i.e. parent, POA,etc.):

Print Name: _____

Source of Authority: _____

If there is anyone you would like to have access to your account or appointment information (including your spouse), please list their information below:

Name, Relationship and Phone Number of those who may have access to my appointment, account, and clinical treatment information:

_____ _____

☐ **I DECLINE TO SIGN THIS FORM**

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement, 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 _____
Other (please describe) _____ Signature of Privacy Officer_____