RELEASE OF INFO AUTHORIZATION

Name _____ Date of Birth _____

Dr. Verle Thompson III is authorized to release protected health information about the named patient above to the following listed entities:

Name of person _____ Relationship _____

Name of person _____ Relationship _____

Please initial <u>each</u> entity that you authorize Peachtree Dental and Dr. Thompson to supply information:

___Leave information on voice mail ___ Release financial information ___ Give information to spouse ___Give information to a parent (if patient is over 18) ___Give information to grandparent

SOCIAL MEDIA

We love our satisfied customers and may ask to use a photo of you on social media or our website. We will always ask your express permission each time we do this. Please initial if you will allow a photo to be used online. Initial _____

YOUR RIGHTS

- I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Dr. Verle Thompson III.
- I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective from that time forward.
- I understand that the information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this form.
- This authorization shall be in effect until revoked by the patient or representative signing this form.

_____ Date _____

Signature of Patient/Parent/Legal Guardian/Representative

(If signed by a **representative** of patient, please attach necessary documentation for this authority)

PEACHTREE DENTAL

PEACHTREE DENTAL

Acknowledgement of HIPAA Privacy Practices & Scheduling Policy

I acknowledge that I have received a copy of this dental practice's HIPAA Notice of Privacy Practices, Scheduling Policy, & Financial Policies.

_____
Print Name

_____ _____
Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (Check One):
__Parent __Guardian __Power of Attorney __Other: _____

Please Note: It is your right to refuse this acknowledgement.

Office Use Only

I tried to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:
__ An emergency prevented us from obtaining acknowledgement.
__ A communication barrier prevented us from obtaining acknowledgement.
__ The individual was unwilling to sign.
__ Other:
_____

_____ _____
Staff Member Signature Date