YOUR SIGNATURE IS NECESSARY FOR US TO:

1. ***Process all insurance claims,***
2. ***To ensure payment for services rendered,***
3. ***To release medical information to insurance companies, AND***
4. ***To release and/or obtain information to/from other medical/dental providers, when necessary, for your treatment.***

I, authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care

Patient Signature: _____ **Date: _____**

Responsible Party: _____

(Parent, if Minor ONLY)

Office Use Only:

Witness: _____

Health Information Release Form

In order to assist you in receiving your health information from our office, please complete this form.
I, authorize the persons listed below to have access to any and all of my health information. This office is permitted to share any information with them that is disclosed during office visits.

Persons authorized to receive my information (full name, relationship and phone number):

Name **Relationship** **Phone Number**

_____

_____

_____

_____

_____

__ You may notify me or the parties listed above with any information regarding my treatment including appointment reminders, treatment information or prescriptions as follows:

Please mark below which you authorize

__ Yes, I authorize to be contacted by email and voicemail on home, work and/or cell

__ Yes, I authorize to receive documents and information by mail

__ No, I do not authorize to be contacted by email, voicemail or receive documents by mail

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____ _____

Print Name **Patient Signature**

_____ _____

Patient Date of Birth **Today's Date**

Notice of Privacy Practices Acknowledgement

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about your privacy practices, our legal duties and your rights concerning your health information.

I _____ have been given a copy of the Notice of Privacy Practice by Dallas Periodontal Associates PLLC. I have read and understand this information.

_____ _____

Patient Print Name Patient Signature

_____ _____

Patient Date of Birth Today's Date

Office Use Only:

_____ _____

Witness Print Name Witness Signature

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. The "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA" , we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations. Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care options include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests or receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures or protected health information.

The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

The notice is effect as January 2001 and we are required to abide by the terms of thie Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse of you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Humans Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:

The US Department of Health & Human Services

Office of Civil Rights 200 Independent Avenue, S.W.

Washington, D.C. 20201

(202)619-0257

Toll Free: 1-877-696-6775