**BELLAIRE PERIODONTICS**

**HIPAA AUTHORIZATION FOR RELEASE OF**

**PROTECTED HEALTH INFORMATION**

**("Authorization")**

I acknowledge that I have received a copy of this Dental Practice’s **HIPAA Notice of Privacy Practices.**

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| --- |
|   |
| Patient Name (Please Print) |

|  |  |  |
| --- | --- | --- |
|   |  |   |
| Patient 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 to sign this Acknowledgment.**

*Dental 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 acknowledgment.

\_\_\_ The individual was unwilling to sign.

\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|   |  |   |
| Staff Member Signature |  | Date |