HIPAA Authorization to release protected information.
Please Print

I, (patient name) _____ authorize the following person(s) to have access to my personal information covered under the HIPAA Privacy Act. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

NAME RELATIONSHIP

1)_____

2)_____

3)_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at Lacour Family Dentistry, 5400 Lawrenceville Hwy, Ste D, Lilburn, GA 30047

If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

Patient Signature_____ Date_____

HIPAA ACKNOWLEDGEMENT
*** You may refuse to sign this acknowledgment ***

I have reviewed a copy of this office's Notice of Privacy Practices or have requested a written copy.

Print Name _____

Signature _____

Date _____

* For Office use Only *

☐ Individual refused to sign ☐ Communication barriers ☐ Emergency prohibited obtaining the acknowledgement.