Southern Dental Associates

Information posted at www.southerndentalnc.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

_____ _____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment, activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

_____ _____

Signature Date

SDA SOUTHERN DENTAL ASSOCIATES
FAMILY AND PEDIATRIC DENTISTRY

Authorization for Use or Disclosure of Protected Health Information

I, _____, authorize Southern Dental Associates to use and disclose the protected health information described below to the following person(s):

_____

□ Appointment Reminders

□ Billing/Account Information

□ Treatment Needs

□ Insurance Information

□ All Personal Information

□ Other (please specify): _____

This authorization shall remain in effect unless other written notification is given.

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient Date

_____

Patient, Parent/Legal Guardian Signature