SOUTH FLORIDA SMILE SPA, NICOLE M. BERGER, D.D.S.

INDIVIDUAL PATIENT'S AUTHORIZATION

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

PATIENT NAME_____
(Please Print)

SIGNATURE_____

BIRTHDATE_____

DATE_____

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

1. Individual Patient (or Personal Representative) Confirming the Authorization.

I give my authorization to use or disclose my protected dental information as described in Section 2 Below. I give this authorization voluntarily.

Name_____

Street Address:_____

City_____ State_____ Zip Code_____

Telephone Number_____

Email Address_____

2. The Use and/or Disclosure Authorized

Describe in detail the protected dental information you are authorizing to be used and/or disclosed.

_____

_____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use and/or disclose the protected dental information described above.

_____

_____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and/or use your protected dental information.

_____

_____

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

_____

_____

3. Ending the Authorization

Select one of the following two choices.

This authorization will end on the following date:_____

This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Decribe the event below:

_____

_____

4. Changing your Mind about the Authorization

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that I am giving this authorization as a condition of obtaining insurance coverage, and if I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

5. Signing this Authorization Is Not a Condition of Treatment

I understand that under most circumstances a dental care provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. Possibility of Re-Disclosure

I understand that information disclosed under this authorization may be re-disclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient re-disclosed my health information.

7. Individual Patient's Signature

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

SIGNATURE_____ **DATE**_____

If this authorization form is being signed by a personal representative for the individual patient:

Personal Representative's Name:_____

(Please Print)

Signature:_____

Relationship to Patient:_____

You have a right to have a copy of this form after you sign it. Submit the authorization to the Privacy Officer and include a copy in the individual patient's dental record.