

Patient Authorization Form

5/08

Family & Cosmetic Dentistry of Nashville, D/B/A Ralph J. Sharow, DMD, in compliance with HIPPA regulations request the following information from (Please Print) _____

I hereby authorize you to use or disclose the specific information:

Description of disclosed information:

- * Receiving recall cards for verification of appointments
- * Displaying my name on the sign in sheet
- * Receiving a message via recorder or voice mail to confirm appointments
- * Receiving a statement via mail for collection purposes

I understand that: I may inspect or copy the protected health information to be used or disclosed.

- * I may revoke this authorization in writing by contacting our office at the address above, attention privacy officer.
- * Information used or disclosed pursuant to authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA.
- * I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that related treatment.

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (HIPPA)**, I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- *Obtain payment from third party payers.
- *Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its policy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature _____ **Date** _____

Relationship to Patient _____