SOUTHWEST DENTISTRY

Personal Information Consent and Authorization

The Health Insurance Portability and Accountability Act (HIPAA) is a law implementing national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. This form allows the disclosure and authorization of your personal health information to be released to whom you specify. This may include X-Rays, treatment plans, financial records, and other information pertaining to your records with Southwest Dentistry. Information disclosed to specified individuals may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I, _____, give my permission to share information concerning the following:

- ☐ My Dental Treatment
- ☐ The Cost and Financial Arrangements for My Dental Treatment
- ☐ My Personal Health Information
- ☐ Other (Please Specify) _____

I give my permission to share the above noted information with the following:

- ☐ My Spouse (Name) _____
- ☐ My Parent(s) (Names) _____
- ☐ My Adult Child or Children (Names)_____
- ☐ Other (Please Specify) _____

- ☐ I, _____, DO NOT give my permission to share ANY information regarding my treatment, Financial Arrangements or Personal Health Information with the exception of what is outlined in the SOUTHWEST DENTISTRY LLC HIPAA policy.

Printed Patient Name: _____
Patient, Parent/Guardian Signature:_____
Date: _____
Practice Witness: _____
Date: _____

- ☐ Cell Phone: _____ Ok to leave a message? Y N ☐☐
- ☐ Home Phone: _____ Ok to leave a message? Y N ☐☐
- ☐ Work Phone: _____Ok to leave a message? Y N ☐☐
- ☐ Email _____Ok to leave a message? Y N ☐☐

You may revoke authorizations at any time by written or electronic note explaining the changes in the authorization. Please send them to our business addresses or email info@sw-dentistry.com. The only exception to your right to revoke authorization is if we have already acted in reliance upon the authorization. Signing this form is voluntary and indicates you have read and understand the HIPAA law and authorize the disclosure of personal health information to specified parties in this form.