SOUTHERN ROOTS
PERIODONTICS AND DENTAL IMPLANT SPECIALISTS

Privacy Practices Consent

Last Name ______________ First Name ______________ Birthdate
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I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use of disclosure that occurred prior to the date I revoke this consents is not affected.

Please name anyone you would like us to release records to below:

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☐ By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.

Signature Here: ____

☐ Patient has been provided with the privacy practices in place by Southern Roots Periodontics and exercized their legal right to refuse to sign. The patient reveiwed the privacy practices and was given the opportunity to ask questions.

Office Manager/Representative Signature: ______________________________ Date: ______________________