SOUTHERN ROOTS
PERIODONTICS AND DENTAL IMPLANT SPECIALISTS

# HIPAA Acknowledgment

Last Name First Name Birthdate

_____

I understand that I may inspect and/or retain a copy of the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authroization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

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

Sign Here

_____

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

_____

_____

☐ 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: _____