HIPPA ACKNOWLEDGEMENT

I understand that I may inspect or copy 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 authorization 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 the 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.

I authorize this office to disclose or discuss my personal and/or dental information with the following person (s).

(Please enter name and relationship to patient)

I understand the above information and agree with its contents.

First Name:_____Last Name:_____

Relation: _____

Patient's Signature: _____