## HIPAA Acknowledgment & Authorization to Release

**Patient Name:**_____

Charlotte Progressive Dentistry is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

| **Entity to Receive Information**<br>Check each person/entity that you approve to receive information | **Description of Information to be released**<br>Check each that can be given to person/entity on the left in the same section |
|---|---|
| Voice Mail | Results of lab tests/x-rays<br>Other: _____ |
| Spouse (Provide Name & Phone Number) | Financial |
| _____ | Medical as follows:_____ |
| Parent (Provide Name & Phone Number) | Financial |
| _____ | Medical as follows:_____ |
| Other (Provide Name & Phone Number) | Financial |

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.* This authorization shall be in effect until revoked by the patient.

I, _____ acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information
- My privacy rights with regard to my protected health information
- This office's obligations concerning the use and disclosure of my protected health information

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revision upon request.

I also understand that if I have any questions or complaints, I may contact **Charlotte Progressive Dentistry**.

Some information, such as HIV, genetic, alcohol and/or substance use disorder treatment record, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

In no event will we disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Signature: _____Date: _____

Name (Print): _____Relationship to Patient:_____

**Office Use Only**

We were unable to obtain a signed acknowledgment for the following reasons:

Patient refused to sign. Date:_____ An emergency situation prevented us from obtaining an acknowledgement

Communication barriers prohibited obtaining an acknowledgment Other:_____

Attempt made by:_____ Date:_____