HIPPA Health Information Sharing Release Form

I,_____hereby authorize the following person (s) the ability to disclosure and release of any of my individual personal information pertaining to past, present or future dental health treatment to any of my immediate adult family members.

_ _ _ _ _ _ _ _ _ _ _ _Name _ _ _ _ _ _ _ _ _ _ _ _Relationship

_____N.ame_____Relationship

To be treated as I would be in regards to respect of my rights regarding the use and disclosure of my individual identifiable dental health information and records. My family members may make use of any information and or records pursuant to this authorization in order to carry out his or her duties toward me as determined having the power and authority to do any or all of the following:

(a) Request, review and receive any form of dental information, oral or written including clinical notes, x-rays, treatment plans needed, completed dentistry, dental insurance, and finances associated with any or all of my dental treatment.
(b) Can execute on my behalf any releases or documents that may be required in order to obtain information including, but not limited to: Valid Authorization to share information under the Ohio Confidentiality of Dental Information Act and Insurance Portability and Accountability Act.

This authorization is effective immediately. The authority given shall supersede any prior agreement I may have made with my dental provider, to restrict access or to disclose any of my individual dental information. This authority has no written expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my dental care provider.

Signature:_____Date:_____

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New Albany, Ohio 43054
(614) 775-0840

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health/dental information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up the multiple healthcare providers who may be involved directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians/dentists certifications.

I acknowledge that I have the right to respect a copy of the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare/dental options. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relations to Patient: _____

Patient Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____