Dental Remedies

135 Jenkins St. Ste. 105A

St. Augustine, FL 32086

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at anytime, 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.

Please check all that apply:

- ○ You may contact me at me home telephone number
- ○ You may contact me on my mobile telephone number
- ○ You may contact me on my work telephone number
- ○ You may send me an email
- ○ Other

Please list authorization persons with whom we may discuss your protected health information (PHI) in addition to custodial parents and legal guardians: (example: John Doe(212-555-1212)

_____

- ○ By checking this circle, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPPA Disclosure Form.

Name of Person completing this form:

_____

Relationship to patient:_______________________________________ Date:________________________