amberlydental

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Waverly, NE 68462

Phone (402) 786-2007
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Receipt of HIPPA Privacy Practices/Authorization

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I acknowledge that I have received a copy of this dental practice's HIPAA Notice of Privacy Practices. In addition, I authorize Amberly Dental to use and/or disclose protected health information (PHI) about me to

_____, _____,

_____, _____.

This authorization permits Amberly Dental to use and/or disclose the following individually identifiable health information about me. The information to be used or disclosed includes but is not limited to: date(s) of services, type of services, all details of services, or origin of information.

The information will be used or disclosed for any purpose deemed necessary by Amberly Dental.

This purpose is provided so that I can make an informed decision whether to allow release of the information. This authorization will good until I specifically inform Amberly Dental in writing otherwise.

The Practice may or may not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Amberly Dental. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Amberly Dental

13220 Callum Dr. Ste. 5

Waverly, NE 68462

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Patient's Name — Date

_____

Print Name of Patient or Legal Guardian, if applicable

Submit