**Notice of Privacy Policies**

The undersigned acknowledges receipt a copy of the currently effective Notice of Privacy Practices for Carolina Commons Dentistry. My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor/facilities in the future.

I have had full opportunity to read and consider the contents for the Notice of Privacy Practices. I understand that I am giving my permission to use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I understand that I have the right to revoke permission.

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 Signature of Patient Date

**Authorization for Release of Information**

I authorize Dr. Sagunarthy and the staff to convey information about my health, appointments, treatment & billing information via the following:

* Voicemail
* Email
* Work and
* Text Messages

I authorize Dr. Sagunarthy and the staff to release information about my treatment or financial matters to:

Spouse: (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent: (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rights of the Patient:

* I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy protected dental 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 disclosed as a result of this authorization may subject to re-disclosure 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.

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Signature of Patient Date