BRASSFIELD
COSMETIC & FAMILY
Dental Center
ROBERT M. YOUNG DDS PA

Privacy Authorization and/or Privacy Disclosure

I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of dental health benefits. I also understand that if my Authorized Representative is no a health care provider or another entity subject to federal or applicable state privacy laws, my person health information may no longer be protected by those privacy laws and my personal health representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative:

Name: _____
Address: _____
Phone Number: _____
Relationship to you: _____

Authorized Representative:

Name: _____
Address: _____
Phone Number: _____
Relationship to you: _____

I understand that I have the right to limit the information that you release under this authorization. For example, I may LIMIT my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on my disclosure.

Limitations on Disclosures:

_____

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: _____
_____

I have reviewed this form entirely and understand my rights regarding granting authorization.
I have received and/ or reviewed a copy of the Notice of Privacy Practices for Brassfield Cosmetic & Family Dental Center located at 3800 Robert Porcher Way Ste. 100 Greensboro, NC 27401.

_____ _____
Signature (Patient or Parent/Guardian for minor) Date

*** For Office Use Only ***

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

___ An emergency existed & signature was not possible at the time.
___ The individual refused to sign.
___ A copy was mailed with a request for a signature by return mail.
___ Unable to communicate with the patient for the following reason:
_____
___ Other: _____

_____ _____
Employee Signature/Position Date