HIPAA Disclosure and Privacy Agreement

Integrated Dental respects the privacy of our patients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities. To ensure that Integrated Dental is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to complete and sign this form. Integrated Dental will keep a copy of your written permission on file.

Please **CIRCLE** do or do not:

- I **DO** or **DO NOT** give Integrated Dental permission to leave detailed information on **voicemail** regarding either treatment or finances regarding my dental/medical care.
- I **DO** or **DO NOT** give Integrated Dental permission to **text** detailed messages to my Personal Cell Phone regarding either treatment or finances regarding my dental/medical care.
- I **DO** or **DO NOT** give Integrated Dental permission to email detailed information to my **email address**, regarding either treatment or finances regarding my dental/medical care.

Email Address: ____

I specifically release permission for Integrated Dental to discuss my dental conditions with the following individuals (Please note, you MUST list your spouse or parent – they ARE NOT automatically added to your chart).

1. ____Relation: __________________
2. ____Relation: __________________

I am not required to sign this authorization. Integrated Dental does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I can request a copy of this authorization be mailed to me. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of any information and audio/video/photographic material.

I am aware that my protected health information will exist forever in either a recorded, printed, and /or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used. I understand that information about me or my child used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual 's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law.

I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to the Integrated Dental Privacy Officer at 1435 S. Tamiami Trail, Suite B, Sarasota FL 34239. I understand that Integrated Dental, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Integrated Dental's control that have not been previously published. If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it.

Patient Name: ____
(First) (m. initial) (last)

Signature: ______________________________________ Date: _________________________

For personal representatives only - please provide the following:

I, _______________________________, represent that I am the heath care agent/ guardian/surrogate/parent of the patient above.

Personal Representative Signature: _________________________________ Phone: _____________________________

Address: ____

*If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient.