

South Hill Periodontics, 2700 S. Southeast Blvd., Ste 210, Spokane, WA 99223

Office Phone: (509) 536-7032, Office Fax: (509) 536-7002

Dr. Anthony G. Giardino, D.D.S., M.S.

Dr. Dwight L. Johnson, D.M.D., M.S.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____

Patient number _____

Patient address _____

Patient phone number _____ H: _____ C: _____

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of South Hill Periodontics. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

South Hill Periododontics reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
SPOUSE ONLY	YES	NO
OTHER (PLEASE SPECIFY) _____	YES	NO

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

RELEASE OF BENEFITS AND INFORMATION

I also authorized my insurance company benefits to be paid directly to *South Hill Periodontics*. I am financially responsible for any balance due, including for services exceeding the limitations of my insurance policy. I authorize *South Hill Periodontics* or insurance company to release any information for claims

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____

Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____