Robert Perrott DMD
7200 Bristlewood Drive
Boardman, Ohio 44512

# Acknowledgement of Privacy Practices

I authorize _____ (Robert Perrott DMD and Associates) to use and disclose the protected health information described below to:

- authorize the release of my complete health record to provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly;
- Obtain payment from third-party payers for my health care services;
- Conduct normal health care operations such as quality assessment and improvement activities.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such 'Notice of Privacy Practices.' I understand that my dental provider has the right to change the 'Notice of Privacy Practices' and that I may contact this office at the address above to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you agree then you are bound to abide such restrictions.

Patient Name: _____ Date: _____

Patient / Responsible Party Signature: _____