HIPPA NOTICE OF PRIVACY PRACTICS

I understand that as part of my healthcare, Forest Hill Endodontics originates and maintains health records that include my health history, charting notes relating to my dental care, test results, and treatment plans. I understand that this information serves as a basis for planning my care and treatment. I understand that this information is a means of communication with other healthcare professionals who contribute with my care. I understand that this information is a means by which a third-party payer can verify that services billed were provided.

I hereby specifically authorize disclosure of my protected health care information to the person indicated below. Check all that apply.

☐ Spouse:____________________________

☐ Other: ___________________________ Relationship:______________________

☐ None

I acknowledge that I have read a copy of Forest Hill Endodontics HIPPA Notice of Privacy Practices.

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Printed Name Date

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Signature of patient, parent, guardian or power of attorney