
# HIPAA ACKNOWLEDGEMENT

Beacon Dental Center, P.C. is HIPAA Compliant. We cannot disclose health information to anyone other than those you choose to list. A formal copy of the Notice of Privacy Practices is available upon request.

This form is to confirm your authorization to use or disclose your protected health information.

Please list all family members, guardians, individuals, or organizations with whom we may discuss or disclose your protected health information with (including medical history, treatment plans and medications).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

You may alter or revoke this agreement at any time; you may do so in writing or in person. Individuals presenting themselves as Legal Guardians or Durable Power of Attorney to you, not listed above, will be required to present documentation attesting their legal status.

I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of my protected health information with the individuals and/or organizations listed above.

_____ Date: _____

Signature