Hartley Bridge TMJ & Dental Sleep Center

Authorization for Additional Disclosure

I certify that I am the patient or legal guardian to the individual(s) listed below and have legal authority to make healthcare decisions of the individual(s) listed below.

Patient(s) ____

I authorize the following individuals to have access to health information:

	Name	Relationship
1.	____	________________________
2.	____	________________________
3.	____	________________________

____	________________________
Patient or Parent Signature	**Date**

In general, the HIPAA privacy rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) may be made by alternative means, such as, sending information to the individual's office instead of their home.

I wish to be contacted in the following manner **(check all that apply)**

- ○ Home Phone/Cell Phone
- ○ Ok to leave message with detail
- ○ Ok to leave call back number only
- ○ Ok to speak with spouse/sibling
- ○ Written Communication/Email
- ○ Ok to write email with detail

I give Hartley Bridge TMJ & Dental Sleep Center permission to use and disclose PHI necessary to carry out TPO (Treatment Payments or Operations) this also indicates a "Good Faith Effort" was made on behalf of Dr. Leigh Bennett. By signing this form, I understand that the privacy practices of the office have been disclosed to me. This information will stay on record for six years.

____	________________________
Patient or Parent Signature	**Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

____	________________________
Patient or Parent Signature	**Date**