8408 davis blvd. #250
north richland hills, tx 76182

O - 817.812.2082
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chad c. perry, dds

PATIENT HIPAA AUTHORIZATION FORM

Our Notice of Privacy Practices provides information about how we use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this disclosure, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:
* Protected health information may be disclosed or used for treatment, payment or health care operations
* The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice
* The Practice reserves the right to change the Notice of Privacy Practices
* The patient has the right to restrict uses of their information
* The patient may revoke this authorization in writing at any time and all future disclosures will then cease
* The Practice may condition receipt of treatment upon execution of this Authorization

I acknowledge that I have read the above authorization and have had access to read the full Notice of Privacy Practices of Chad C Perry, DDS.

_____ _____
Signature Relationship to patient

_____ _____
Printed Name – Patient or Representative Date

_____ _____
Witness Signature – Practice Representative Date