BURROW ORTHODONTICS

S. "Jack" Burrow, III, DDD, M
Diplomate American Board of Orthodontics
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Eastover Medical Park
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704-334-7202

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

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 operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:____

Responsible Party: ____

Relationship to Patient:____

Signature Patient/Responsible Party____

Date:_________________________________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

Please Turn Over To Complete.

HIPAA Authorization for Release of Information to Family and/or Friends

Name of Patient: ___________________________________ Date of Birth: _______________________

Burrow and Case Orthodontics is authorized to release protected health information about the about named patient to the following listed entities:

ENTITY NAME: ____________________________________ RELATIONSHIP: __________________

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Please initial each situation giving Drs. Burrow and Case your authorization to supply information to your entity:

_____ Leave information on voice mail
_____ Release financial information
_____ Give information to spouse
_____ Give information to grandparent
_____ Give information to parent
(patient is over 18 years of age)
______ Email (for e-mail communication, I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communication.)

____ Medical information as follows:____

_____Other information as described: ____

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Drs. Burrow and Case. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

____Date: _____________________

Signature of Patient/Parent/Legal Guardian/Personal Representative

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Description of Personal Representative's Authority (attach necessary documentation)