ATHENS SMILES, LLC
1289 CEDAR SHOALS DRIVE
ATHENS, GA 30605
706-353-7018

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA POLICIES AND PROCEDURES

CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

I have agreed to let certain individuals participate in discussions and decisions related to my medical /dental care. Therefore, I hereby give my permission for Athens Smiles to disclose my personal medical/dental information to the following individual(s): (check blank or fill in space).

_____ Anyone Athens Smiles feel necessary in order to give me the best care.

OR

NAME:_____ RELATIONSHIP:_____

NAME:_____ RELATIONSHIP:_____

NAME:_____ RELATIONSHIP: _____

This practice may disclose my medical/dental information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile or regular mail.

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

I understand that this consent may be revoked by me at any time by written notice to this practice.

Print Name:_____

Patient Signature:_____

Date of Signature:_____

Witnessed By:_____Title/Position_____

Print Name of Witness:_____Date:_____

WE ARE NOT A MEDICARE PROVIDER.