# Wilson Park Dental

## AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996, Wilson Park Dental may not use or disclose your health information without your authorization except as provided in our Notice of Privacy Practices. Your signature on this form indicates that you are giving permission for the use and disclosure described herin. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

**AUTHORIZATION SECTION**

I, ______________________________, (print patient name or name of minor child) hereby authorize and request the use and disclosure of all of the health information that pertains to me. I authorize and request Wilson Park Dental to make these disclosures of my health information. I authorize and request the following persons to receive these disclosures of my health information and elect not to provide statement of purpose for the use of the disclosure to the following persons (please print):

______________________________ ______________________________

Name Relationship

______________________________ ______________________________

Name Relationship

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer be protected.

I understand that this authorization will automatically expire one year from signature date, but that i may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Wilson Park Dental. I further understand that any such revocation does not apply to the extent that person authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.

______________________________ ______________________________

Signature of Patient or Parent of Minor Child Date

**Only complete this section if you wish to revoke this authorization:**

I revoke this authorization effective ______________________________ (date).

______________________________ ______________________________

Signature Date

Wilson Park Dental

807 St. Andrew Street, Rapid City, SD 57701 * 605-343-9352 * Fax 605-343-3115

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgement**

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

________________________________________________
Please Print Name

________________________________________________
Signature

________________________________________________
Date

________________________________________________
Witness Date

---

**FOR OFFICE USE ONLY**

---

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

____________________________________________________________

____________________________________________________________