Dentistry
at Pioneer Woods

4131 Pioneer Woods Drive
Lincoln, NE 68506
P: 402.489.3453
F: 402.488.1119

Receipt of HIPPA Privacy Practices/Authorization

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I acknowledge that I have received a copy of this dental practice's HIPPA Notice of Privacy Practices. In addition, I authorize Dentistry at Pioneer Woods to use and/or disclose protected health information (PHI) about me to:

_____ , _____

_____ , _____

This authorization permits Dentistry at Pioneer Woods to use and/or disclose the following individually identifiable health information about me. The information to be used or disclosed includes but is not limited to: date(s) of services, type of services, all details of services, or origin of information.

The information will be used or disclosed for any purpose deemed necessary by Dentistry at Pioneer Woods.

This purpose is provided so that I can make an informed decision whether to allow release of the information. This authorization will be good until I specifically inform Dentistry at Pioneer Woods in writing otherwise.

The practice may or may not receive payment or other remuneration from a third party in exchange for using the PHI.

I do not have to sign this authorization in order to receive treatment from Dentistry at Pioneer Woods.
In fact, I have the right to refuse to sign this authorization. When my information is used for disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Dentistry at Pioneer Woods
4131 Pioneer Woods Drive, Suite 101
Lincoln, NE 68506

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Print Patient's Name — Date

_____
Print Name of Patient or Legal Guardian, if applicable