Notice of HIPAA Privacy Practices

Winterholler Dentistry is disclosing this policy as required by Federal and Montana State regulations. I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, procedures and diagnoses, and treatment plans for the future care.

I am aware that I may request a copy of this office's Notice of Privacy Practices at any time. I understand that I have a right to review the notice prior to signing this consent. I also understand that Winterholler Dentistry reserves the right to change their notice and practices and I will be notified of these changes. I understand that I have the right to place additional restrictions on the use or disclosure of my health information. I also understand Winterholler Dentistry is not required to agree to the restrictions requested.

RELEASE OF INFORMATION

I authorize Winterholler Dentistry to disclose protected health information as detailed below. Please include anyone who you authorize to receive information about appointment dates/times and/or dental treatment and account status including: spouse, family members (parents/adult children), caregivers, etc. ☐ **DO NOT RELEASE TO ANYONE.**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization for release of information covers the period of healthcare specified below (chose one):

- ☐ All past, present, and future periods.
- ☐ Limited Dates from _____ to _____

This authorization is in effect until (chose one):

- ☐ Always in effect; no expiration
- ☐ Five (5) years

This dental information may be used by the person(s) above for dental treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may refuse to sign this Notice of Privacy Practices. Refusal to sign will restrict release of protected health information to the patient only. ☐ **SIGNATURE REFUSED.**

Signature of Patient / Guardian: _____ Date: ____/____/____

Patient Name (Print): _____

Relationship to Patient: _____

WINTERHOLLER
Dentistry & Implant Surgery