Eastside Dental

FRANK R. GALKA D.D.S.
KURT G. BEHLMER D.D.S.

HIPAA PRIVACY AUTHORIZATION FORM

Authorized for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act-45 CFR Parts 160 and 164)

I, ____, give permission to **Eastside Dental Office** to:

☐ Not use and disclose protected health information to anyone.
☐ Use the following protected health information, and/or
☐ Disclose the following protected health information to:
(Example: Family members, friends, lawyers or someone with whom you wish to share your records.)
Please list the names of the people you would like to have access to your records.

____
____
____

Information to be disclosed *(check all that apply)*:

☐ Medical Records
☐ Dental Records
☐ Treatment Records
☐ Diagnostic Records
☐ Other: ____
____

Authorization for release of information covering the period of health care from
☐ ___________to____________
OR
☐ All past, present and future periods

I understand I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

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.

Finally, I understand that I have the right to revoke this authorization in writing at any time by sending written notification to ***Eastside Dental at 1845 N Farwell Ave, STE 105, Milwaukee, WI 53202***. My notice will not apply to actions taken by the requesting person/entity prior to the date they receive my written request to revoke authorization.

☐ I acknowledge that Eastside Dental's staff gave me a copy of Notice of Privacy Practice.

______________________________ ______________________________
Patient/Guardian Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of HIPAA Form, but acknowledgment could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgment
☐ An emergency situation prevented us from obtaining acknowledgment
☐ Other (Please Specify)

____

______________________________ ______________________________
Staff's Signature Date

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As a friendly reminder, we have Broken Appointment and Late Cancellation policies.

Broken Appointment Policy:

One broken appointment (i.e. missed appointment) will incur no additional fee.
Two broken appointments will incur a broken appointment fee of $98.
Three broken appointments will incur another fee and the patient will be required to prepay for any future appointments.

Late Cancellation Policy (less than 48 hours):

One cancellation will incur no additional fee.
Two cancellations will incur an additional cancellation fee of $98.
Three cancellations will incur an additional cancellation fee and the patient will be required to prepay for any future appointments.

Print Name ______________________ Patient Signature ______________________

It is at our discretion to excuse any patient from the dental practice.