SWISHER & ASSOCIATES
TOTAL DENTAL CARE

Notice of Privacy Policies & HIPAA Authorization

Last Name: First Name: Birthdate:

I acknowledge that I have received and/or had the opportunity to review the Notice of Privacy Practices. I understand that my protected health information (PHI) may be used and disclosed for purposes of treatment, payment, and healthcare operations without additional authorization as permitted by law. I authorize Ryan S. Swisher, D.D.S. & Associates to use and disclose my PHI as described. This authorization applies to all dental and related health information unless otherwise specified and I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

I understand that signing this authorization is voluntary, and that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. Information related to substance use disorder diagnosis, treatment, or referral may be protected under federal law (42 CFR Part 2) and will not be disclosed without specific written authorization where required.

I authorize the following individuals to have access to information regarding my dental care:

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

May we contact you via (check all that apply): ☐Phone ☐Text ☐Email

May we leave voicemail messages? ☐Yes ☐No

I understand that text and email may not be secure and consent to receive communications via these methods.

Patient Rights: I understand my rights to access, amend, and request restrictions on my health information.

Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA.

Patient/Guardian Signature:

X_____

Date:

This authorization expires three (3) years from the date of signature unless revoked earlier in writing.