Politimi DDS
Mantzouranis
Cosmetic Smile Design & Family Dentistry

HIPPA Authorization Form

By signing below, you consent to the use and disclosure of your protected dental and health information by Politimi Mantzouranis D.D.S., staff, and referring doctors for treatment, payment, and any other health related information.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Mantzouranis reserves the right to revise it's Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the privacy officer.

With my permission, the office of Politimi Mantzouranis D.D.S may call my home, work, cell or other designated locations and leave voice messages, email, or paper mail to an address provided by myself.

This form is also used to obtain acknowledgement or receipt of our notice of privacy practices or to document our good faith effort to obtain that acknowledgement.

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent.

Patient Name: _____

Patient Signature:_____

Date:_____

Please list any other person(s) you give permission to speak with regarding any treatment or financial aspect at our office:_____

Expect the extraordinary !!!

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