

Wilmington Periodontics & Implant Center

wilmingtonimplantcenter.com

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(910)772-9770

Patient Name: _____
Last First MI Preferred Name

Your privacy is very important, and we value and respect your privileged health information. We utilized different methods of communication to keep you informed and apprised of any schedule changes, appointment reminders, insurance/billing issues, or medication instructions. Please indicated in the space provided your preferred contact person. *

I understand that some forms of communication are more secure than others. I understand that if patient information is not sent in an encrypted manner Please indicate your preferred method of communication: *

Phone Text message Email

Please provide the most up-to-date contact information:

*

In the event of an emergency please contact: *

Patient Authorization:

I authorize the use and disclosure of any or all of my periodontal records, including but not limited to my name, photos, records, slides, radiographs, and other viewings of my care and treatment before and after completion of procedures for research, education, and promotional purposes.

1. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the periodontist at the address as noted on top of this form.
2. I understand that I may refuse to sign this authorization and that the periodontist may not condition my treatment on whether I provide this authorization.
3. I understand that this authorization will expire one year after the date of my death.
4. I understand that no recipient of my periodontal information is covered by the federal privacy regulations that protect the privacy of healthcare information, and that after its release, my information will be subject only to the recipient's privacy policies and not to federal law.
5. I understand that I may receive a copy of this authorization by submitting a request to the periodontist at the address noted on the top of this form.

Patient Rights:

- I understand that I have the right to revoke this authorization at any time.
- I understand that I may request a copy or inspect the protected health information to being disclosed to my doctor.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I have read and provided the information to the best of my ability. This authorization will remain in effect until revoked by the patient.

Signature _____ Date _____

Response Date: ____/____/____