Wilmington Periodontics & Implant Center

1611 Doctor's Circle • Wilmington, NC 28401 (910)772-9770

Patient Name: _____ _____ ___ _____
Last First M Preferred Name

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

_____

_____

_____

I understand that some forms of communication are more secure than others. 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 thatI 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: _____