HIPAA Acknowledgement
(Health Insurance Portability and Accountability Act)

A.M. DeLoach, DDS, LLC
Phone 478-224-5656
1113 Morningside Drive, Perry, GA 31069

Patient Name: ______________________________ **DOB:**_______________

1. **We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. Said "Notice" is available to you in the patient waiting area of our office. This Notice describes how we protect your health information and what rights you have regarding it.**
2. **This "Notice" also lists the various agencies of our government which have the right to request your health information from us.**
3. **Authorization for Release of Identifying Health Information:**

Please list below the names of the individuals closest to you whom you wish to have access to the information which we have in your records, including dates and times of upcoming appointments:

____
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I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____________ **Patient Signature**__________________________________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: ____________________

Print Name: ____________________________