Yangsun (Paul) Bak, D.D.S.

WINDWARD
PEDIATRIC DENTISTRY, P.C.

Rachel K. Keleske, D.D.S.

PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT

I have been told that ***Windward Pediatric Dentistry*** has a Privacy Policy in place according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a patient of Windward Pediatric Dentistry, I understand and acknowledge the following:

- ***Windward Pediatric Dentistry*** has a privacy policy in effect in their office.
- ***Windward Pediatric Dentistry*** has made this policy available to me and has made me aware, that as a patient, I am entitled to a copy of this privacy policy if I desire a copy for my personal files.

After reading these statements please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by ***Windward Pediatric Dentistry***, and have read and understand the acknowledgement form. If you would like a copy of the privacy policy, please ask for one at our front desk.

________ **No, I do not want a copy of the policy but I do acknowledge that it exists.**

________ **Yes, I have requested and been given a copy of the privacy policy.**

Patient Name Date

Patient Name Date

Patient Name Date

Patient Name Date

Parent/Guardian Signature Date

For more information, please contact Windward Pediatric Dentistry at (770) 344-0170.

www.wpdentistry.com

Tel: (770) 344-0170 / Fax: (770) 344-0169 ■ 11730 Jones Bridge Rd. Suites B,C & D, Alpharetta, GA 30005

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name ______________________ DOB ______________________

Patient Name ______________________ DOB ______________________

Patient Name ______________________ DOB ______________________

Patient Name ______________________ DOB ______________________

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: Dental records.
2. To whom may the information be released [name(s) or class(es) of recipients]: Physician, Dentist.
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual): At the request of the individual.
4. Expiration date or event relating to the individual or purpose for the release: When individual is no longer a patient of record at Windward Pediatric Dentistry.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the tip of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

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/Guardian 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 ______________________

Source of Authority ______________________

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