Dr. Jodi H. Foy DDS, PA

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Electronic Communications Disclosure

We may disclose Patient Health Information (PHI) to third parties that perform services for Jodi H. Foy DDS, PA in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Jodi H. Foy DDS, PA in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.

Please sign below that you agree to allow us to use this information in providing your services.

____

Signature   Date

---------------------------FOR OFFICE USE ONLY-----------------------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)

____

Authorization for Release of Information
To Family and/or Friends

Name of Patient_______________________________ Date of Birth__________

Dr. Jodi H. Foy, DDS, PA is authorized to discuss my dental care and may release my confidential health information to the following:

___________________________________ ___________________________________
Name Relationship

___________________________________ ___________________________________
Name Relationship

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Dr. Jodi H. Foy, DDS, PA 217 W. Millbrook Road Suite D, Raleigh, NC 27609.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effective until revoked by the patient or representative signing the authorization.

____ Date_____________________
Signature of Patient or Personal Representative

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Description of Personal Representative's Authority (attach necessary documentation)