SHORT FORM
Privacy Consent Form / Required by Federal HIPAA Law #101-191
For Use or Disclosure of Private Health Information

- Trust is the foundation of a doctor/patient relationship
- The information that you provide us is kept in the strictest of confidence
- While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your health care information:
  1. It may be necessary to use or disclose your private health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health information.
  2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services
  3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes.

Please note:
We have a more detailed "Notice of Privacy for Private Health Information" and you have the right to review the detailed notice before you sign this consent form. We have the right to change our privacy practices as described in the detailed notice. If any changes occur in reference to our privacy practices, you will be notified by a posting of the change in the office or a notice will be sent to you in the mail. You may request a copy of our privacy notices at any time.

Patient Rights Under HIPAA LAW #101-191

1. You have the right to request that we do not disclose your private health information to specific Individuals, companies or organizations under the following circumstances:
   a. All requests must be in writing
   b. By law we are not required to agree with your restrictions, HOWEVER,
   c. If we agree with your restrictions, the restriction is binding on us.
2. You have the right to REVOKE your authorization under certain conditions:
   a. It must be in writing.
   b. The request will not be honored if we have already released your private health information before we received your request to revoke the authorization.
   c. If you were required to give your authorization as a condition of obtaining insurance, the insurance may have the right to your private health information should they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I also acknowledge that once I sign this consent form, I will receive a copy of this completed form for my own records.

_____ Royce W. Woolfolk, Jr., DDS
Printed Patient Name — Printed Authorized Provider Name

_____ _____
Signature Date — Signature Date

Authorization for Appointment Reminders and Health Care Information

There may be times when the doctor or members of the doctors team may need to use your private health information such as your name, address, phone number in order to contact you in regards to appointment reminders, requested information about alternative treatment or other health related information. If you are not at home to receive this information we would like to leave you a message. By signing this form you are giving us authorization to contact you and/or leave you a message.

Signature: _____ Date: _____