WILLIAM J. CLAIBORNE, DDS
Specialist in Periodontics

Biltmore Periodontics

William J. Claiborne, DDS 11 Yorkshire Street, Asheville, NC 28803

A. Patient Name ____

B. Authorization of release of information to family and or friends.

Dr. Claiborne is authorized to release protected health/dental information about the above named patient to the entities name below. **Please check all that apply.**

_______ Leave information on answering machine or voice mail _________ Leave message at work

_______ Give information to spouse _______ other _____________________________

C. Authorization for release of information to Dentist/Physician/Insurance Company

Name Physician ____

Name of Insurance Company ____

Name of General Dentist ________________________________

To release information to Dr. William J. Claiborne, DDS, PA, and release any and all results from the physician/dental and any tests performed.

Rights of the patient: I understand that I have the right to revoke this authorization at any time by sending a written notification to the address above. I understand that a revocation is not effective in cases where the information has already been used to disclosed but will be effective going forward. I understand that the 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 inspect or copy the protected health information to be used or disclosed as described in this document by written notification to the address above. 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 is in force until all results from the exam and tests have been delivered as instructed to the names company.

X ____ **Date** ___________________________________

Signature of Patient or Personal Representative

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name ____

Address ___________________________________City______________________State__________Zip___________

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

_X____ __________________________________

Signature **Date**

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

_______ An emergency existed and a signature was not possible at the time.

_______ The individual refused to sign.

_______ A copy was mailed with a request for a signature by return mail.

_______ Unable to communicate with the patient for the following reason ____

Prepared By: _______________________________Signature_________________________________Date_____________