Dr. Natalia N. Antley D.D.S.
2329 Devine St. Columbia, SC 29223 P: 803-799-3368

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgement

I, _____, have received a copy of the Carolina Dentistry Notice of Privacy Practices.

Please Print Name

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:

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

*************PLEASE SEE REVERSE PAGE*************

Consent to Release Information

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), **must first be authorized**. Authorization includes the signature of the individual authorizing the release of their information. Information **will not be available** to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the child's consent.

I want to provide the authorization **YES NO**

Information Regarding Person Authorizing Releasing His/Her Information

Name of person authorizing release _____

Date of Birth person authorizing release _____

Personal Information may be released and/or received by **Phone, E-mail, Mail, Fax**

The following is an authorization allowing Carolina Dentistry to release information to whomever you designate. Carolina Dentistry is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, Prescription, diagnostic, treatment, and/or care management services, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that the office may release my information to _____

Relation of person/organization that the office may release information to _____

Phone number of person/organization that the office may release information to _____

I want to add a second person/organization **YES NO**

Name of person/organization that the office may release my information to _____

Relation of person/organization that the office may release information to _____

Phone number of person/organization that the office may release information to _____

I want to add a third person/organization **YES NO**

Relation of person/organization that the office may release information to _____

Phone number of person/organization that the office may release information to _____

AUTHORIZATION CONSENT

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practices Notice of Privacy Practices.

I confirm and agree

_____

Signature Date