J.STEPHEN WEIR. D.D.S
PRACTICE LIMITED TO PERIODONTICS
5348 Estate Office Drive
Memphis, Tennessee 38119
901-763-4700

Date _____ Patient's Name _____

If a personal representative signs this authorization on behalf of the patient, please provide the following:

Name_____

Relationship to Patient_____

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge receipt of our Notice of Privacy Practices

_____

Signature (parent or guardian to sign if patient is under 18 years of age)

CONSENT FOR USE & DISCLOSURE OF INFORMATION

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations as outlined in the Notice of Privacy Practices. This includes authorizing us to act as your representative with regards to insurance benefits and coverage, claim payments, disputes, approvals and authorizations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

_____

Signature (parent or guardian to sign if patient is under 18 years of age)

PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED INFORMATION TO BE USED AND/OR DISCLOSE (OPTIONAL)

Name or specifically identify these persons and/or entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

Name_____**Relationship**_____

Name_____**Relationship**_____

Name_____**Relationship**_____

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**
- ☐ **Communications barrier prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledegement**
- ☐ **Other (Please Specify)**

_____

_____

_____

Office Personnel Signature _____