GREEN PARK
DENTISTRY

**J. Andrew Sugg, D.D.S., PA**
**AUTHORIZATION TO RELEASE INFORMATION TO FAMILY/FRIENDS**

Name: ______________________________________ Date of Birth: _______________________
J. Andrew Sugg, DDS, PA is authorized to release protected health information about the above named patient to the entities named below:

Initial each that is subject to this authorization:
I prefer appointment reminder calls via (choose one): ______ Phone _____ Text Message _____ Email
____ Leave information on the voice mail _____ Give information to spouse
____ Give information to the following persons: ______________________________________________
Description of information to be released:
_____ Financial Information _____ Results from x-rays
_____ Other information: _____________________________

**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 J. Andrew Sugg, DDS, PA. 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 re-disclosure by the recipient and may no longer be protected by a 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 effect until revoked by the patient or representative signing the authorization.
X_______________________________________________________ ___________________
Signature of patient or Personal Representative Date

**Notice of Privacy Practices**

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices. By signing below, you are agreeing that you have had the opportunity to read our notice of privacy practices.
X_______________________________________________________ ___________________
Signature of patient or Personal Representative Date