ACKNOWLEDGEMENT OF RECEIPT OF TEXAS WOMAN'S UNIVERSITY DENTAL HYGIENE PROGRAM
NOTICE OF PRIVACY PRACTICES AUTHORIZATION

1, (Print name) _____, hereby verify that I have received a copy of the Notice of Privacy Practices of Texas Woman's University Dental Hygiene Program.

Authorization to use or disclose protected health information

- I understand that by federal law, Texas Woman's University Dental Hygiene Clinic may not use or disclose my health information, except as provided in the Dental Hygiene Clinic Notice of Privacy Practices, without my authorization. My signature on the authorization indicated that I am giving permission for the uses and disclosures of the PHI described above. I hereby release Texas Woman's University and its employees from any and all liability that may arise from the release of information as I have directed.
- I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing and address it to the person or institution named above that I am authorizing to disclose my information. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.
- I understand that I may refuse to sign this authorization, I also understand that if Texas Woman's University Dental Hygiene Clinic does not have the necessary radiographs and, or medical clearance needed for treatment I may be refused treatment in the clinic.
- I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.
- I understand that I may be charged a fee for copies of patient records and or duplicates of radiographs.

My signature below means that I have read a copy of Texas Woman's University's Patient Privacy Notice and that **I have no changes** to the names of doctors, dentists, and/or contacts to which my health or dental information may be revealed/discussed via phone, email, fax or mail The names of doctors, and/or dentist given at the top of the health history form are the ones that TWU Dental Hygiene Clinic may contact concerning my dental and/or my health concerns. If you have had changes to your doctors, and/or dentist who we should contact please let us know. _____ (initial)

_____ (Signature)

_____ (Signature of Witness)

Date: _____