



DR. MICHAEL J. FLORENCE • DR. JACK H. LINCKS • DR. RANDY S. DEMETTER
BOARD CERTIFIED PERIODONTISTS • SPECIALIZING IN PERIODONTICS AND IMPLANTS

Notice of Privacy Practices

New federal legislation requires that we issue a notice of our privacy practices. You have the right to the confidentiality of your treatment and medical information. We strive to protect the privacy of this sensitive information and are required by law to do so. If you have any questions about the notice of Privacy Practices in effect, and our legal duties with respect to this, please contact the privacy officer within our practice. All employees, staff, and other personnel in our practice who may need access to your information must abide by this notice. All subsidiaries, businesses associated, sites, and locations of this practice may share medical information with each other for treatment, payment purposes, or other care described in this notice. Only minimum necessary information will be shared.

We reserve the right to change this notice. Before we make significant changes in our policies, we will change our notice and post the new notice in the waiting area. You can request a copy of our notice at any time.

I acknowledge that I have received the Periodontal Health Specialist's Notice of Privacy Policies, which provides the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with the respect to my protected health information.

Signature of Patient or
Parent/Guardian: _____ Date: _____

Release of Records

I authorize the release of my dental records from Periodontal Health Specialists to individuals involved in my dental care. I further authorize individuals involved in my dental care to release to Periodontal Health Specialists, any information pertaining to my dental care. I give permission for the use of periodontal records, which include treatment records, photographs, radiographs, study models, CAT Scans for dental implants, and biopsy reports for the purpose of professional consultation, patient education and research, or publication in professional journals. I hereby authorize Periodontal Health Specialists to submit insurance claims for benefits for services rendered without obtaining my signature.

Signature of Patient or
Parent/Guardian: _____ Date: _____