

Third Party Appointment/Account Authorization

I, _____ (Full Name), am a patient at the Atlanta Dental Group PC.

I understand that the **Health Insurance Portability and Privacy Act (HIPPA)** forbids the doctors and staff at the Atlanta Dental Group PC from sharing information about my dental care with any other person. However, I wish to **waive this right** for the specific activities shown below. I have checked the appropriate activities and initialed each checked activity.

" to make, cancel and/or confirm dental appointments Initials _____

" to access my accounting information Initials _____

" to access my dental and medical information Initials _____

By waiving this right I give the **below named person** permission to act in my behalf via the telephone, in writing or in person.

_____ (Printed Full Name)

I agree to take full and complete responsibility for the above person's acts and I agree to hold the Atlanta Dental Group PC harmless for any harm resulting from my request. In the event that I later wish to retract this permission, I will notify the Atlanta Dental Group PC in writing. By my signature I acknowledge the above request.

_____ (Signature)

_____ (Printed Full Name)

Today's Date: