HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ DOB: _____

Name of parent or guardian (if different than patient): _____

1. I hereby authorize all health care providers to use and/or disclose the protected health information ("PHI") described below to me or directed below. The purpose of this request is for personal reasons.
2. I hereby authorize the release of PHI, defined here as the patient's complete dental record, including treatment, prognosis, financial, billing, and insurance information. I understand that my personal billing, financial and insurance information may be disclosed to those in section 3 in order to be able to process claims with the insurance company and/or for personal reasons.
3. In addition to the authorization for release of my PHI, I authorize disclosure of information regarding my/my spouse or domestic partner/my dependent's billing, condition, treatment and prognosis to the following individual(s) (please caregivers that may accompany children to appointments):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

4. This medical information may be used by the persons I authorize to receive this information for dental/medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and in effect until I am no longer a patient at this practice.
6. I understand that I have the right to revoke this authorization, in writing, at any time. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation.
7. I understand that my dental provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that payment will be collected at the time services are provided and I will be responsible for filing any claims with my dental insurance company.

Messages

Please call ( ) my home ( ) my work ( ) my cell number: _____

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

Signed: _____ Date: _____/_____/_____

Parent/Guardian:_____ Date: _____/_____/_____

Authorization for Release/Use of Protected Health Information In the Form of Photos, Radiographs, and Electronic Images

Your photos and x-rays are part of your diagnostic and clinical record and are considered to be protected health information under federal HIPAA Privacy Laws.

We make use of radiographs (x-rays), photographs, and digital images. These images may be used for diagnosis, documentation, demonstration, education, reference, teaching, and research publication and may appear either in print media, social media, television, on digital media, in our office "before and after" pictures, and on our webpage. In some instances, you may be recognizable in some of these images.

By initialing and signing this form, you are authorizing us and releasing us from any liability resulting from the use/release of such images. Your authorization and release to use images will in no way affect the quality of your results in our office. We do our best to provide exceptional dentistry to all patients.

Check all that apply:

___ I authorize the use of my images and/or photographs where my face is identifiable be displayed in the dental office
___ I authorize the use of my images where only my teeth are identifiable be used for educational purposes and to show treatment options.
___ I authorize the use of my radiographs be used for educational purposes and to show treatment options.

The purpose of this request to release and/or disclose the PHI described above is for personal reasons. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization. This Authorization will expire at such time that:

___ I determine that I no longer wish for my images to be used and I revoke this authorization in writing; or
___ The following date: _____ (*within one year of current date*).

_____ _____
Signature of Patient Date