

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 as 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 paragraph 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 described in paragraph 3 of this Authorization, I authorize disclosure of information regarding my/my child’s billing, condition, treatment and prognosis to the following individual(s) (please include caregivers that may accompany children to appointments):

Name _____ Relationship _____

4. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until I am no longer a patient at this practice, or until such time as I render payment for my own treatment, or _____, (date or event) at which time this authorization expires.

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. 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.

7. I understand that my health care 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.

Signature of Patient

Date

Medical Information Release and Authorization Form

Name: _____ Date of Birth: ____/____/____

Authorization for Release of Information

I authorize the release of information including the entire contents of dental record, including diagnosis, treatment details and financial information. The purpose of this request is for personal reasons.

This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

I understand that I have the right to revoke this Authorization, in writing, at any time by notifying this office. 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 remain in effect until terminated by me in writing or until the following date (within one year of today's date): _____.

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

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/____

_____ Date: _____

Signature of Patient/Parent or Guardian

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

Name of office: _____

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.

I authorize the use of my images where my face is identifiable

I authorize the use of my images where only my teeth are identifiable

I authorize the use of my radiographs

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

MEDICAL RELEASE SPECIAL AUTHORIZATION FORM FOR MINORS

I, _____, (Parent/Legal Guardian) authorize the following person/persons to authorize dental treatment for my child/children by this facility. I also authorize this office to release and/or disclose my child(ren)'s private health information, defined here as the patient's complete dental record, including treatment, prognosis, financial, billing, and insurance information to the personal representatives below.

I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives.

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 decide to revoke this Authorization in writing; OR
___ The following date: _____ (within one year of current date).

NAME OF PERSONAL REPRESENTATIVE	RELATIONSHIP	DOB	Phone#
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NAME OF CHILDREN AGES

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signed by: _____

Relationship to Child: _____ Date: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____

DOB: _____

I authorize the use or disclosure of the protected health information ("PHI") as described below.

Description of PHI: Any and all contents of dental record, including diagnosis, treatment, prognosis, financial, billing, and insurance information.

I authorize _____ (*ofc name*) to release and/or disclose the PHI described above to the following person(s) :

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. However, if I refuse to sign this Authorization, I understand that I will be financially responsible for any dental work provided by this office and will be responsible for filing any claims with my dental insurance company.

This Authorization will expire at such time that:

I become financially responsible for all dental work performed by this office; or
 The following date: _____ (*within one year of current date*).

Signature of Patient

Date

**Personal Health Information Authorization
(HIPAA Release Form)**

Name: _____ Date of Birth: ____/____/____

I authorize the release/disclosure of any and all information including any and all contents of dental record, including diagnosis, treatment, prognosis, financial, billing, and insurance information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

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. However, if I refuse to sign this Authorization, I understand that I will be financially responsible for any dental work provided by this office and will be responsible for filing any claims with my dental insurance company.

This Authorization will expire at such time that:

___ I decide to revoke this Authorization in writing; OR

___ The following date: _____ (within one year of current date).

Messages

Please call my home my work my cell Number: _____

If unable to reach me:

please leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (*day*) _____ between (*time*) _____

I understand that this office will try to accommodate my wishes about my contact information, but may have to contact me at the other numbers if unable to contact me at my requested number/location.

Signed: _____ Date: ____/____/____