HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act

1. I hereby authorize all medical/dental service sources and health care providers to use and/or disclose the protected health information (''PHI''), my dental health record, billing, condition, treatment and prognosis to:

a. The agent identified in my durable power of attorney for health care named ____.

b. To the following individual(s):

Name ______________________________________ Relationship ____________________
Name ______________________________________ Relationship ____________________
Name ______________________________________ Relationship ____________________

c. The Dental Office(s) of:
Dr. ____Phone _________________
Dr. ____Phone _________________
Dr. ____Phone _________________

2. I authorization for release of PHI covering the period of health care:
a. From date ________________ - to date______________________
b. All past, present and future periods.

3. This medical/dental 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.

4. This authorization shall be in force and effect until nine (9) months after my death or _________________________________, (date or event) at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient____Date: ___________