HIPPA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. I hereby authorize ***Special Dental Care*** to use and disclose the protected health information described below to:
   ☐ Self and Insurance Companies (if applicable)
   ☐ Individual/Corporation _____
   Address: _____Phone (____)_____ Fax (____)_____
   ☐ Medical Physician _____
   Address: _____Phone (____)_____ Fax (____)_____
   ☐ Other _____

2. EFFECTIVE PERIOD

This authorization for release of information covers the period of healthcare from:

☐ _____ TO _____
OR
☐ all past, present, and future periods.

3. Information to be disclosed (check all that apply):

☐ Complete Dental/Health Records/Reports ☐ Dental Images

☐ Health Records ☐ Treatment Records

☐ Dental Records ☐ Diagnostic Records

☐ Other: _____

When your Protected Health Information is released as provided in this Authorization, the recipient may not have a legal obligation to protect its confidentiality and may redisclose it.

4. This protected health information is being used or disclosed for the following purposes: treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____, at which time this authorization expires. If no specific date is indicated, this authorization will automatically expire one year after the date that I sign it.

6. 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.

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

8. 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.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient