HIPAA 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. Authorization

I authorize Sunset Dental Care to use and disclose the protected health information described below to ____ (i.e. family member/friend/guardian/caretaker in case we leave a message, you have someone request to change an appointment or pay a bill.)

2. Effective Period

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

a. ☐ _______________ to _________________.

OR

b. ☐ all past, present and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete dental record.

OR

b. ☐ I authorize the release of my complete dental record with the exception of the following information:

☐ X-Rays

☐ Financial Records

☐ List of Treatment Provided

☐ Other (please specify): ___________________________________

OR

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c. ☐ I do not want anyone to have access to any of my dental information.

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

5. This authorization shall be in force and effect until ____________________ (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. 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.

____

Signature of patient or personal representative

____

Printed name of patient or personal representative and his/her/they/them relationship to patient

____

Date