

**Standard HIPAA Authorization Form
To Use of Disclose Protected Health Information**

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. parts 160 and 164)

I _____ have read the Privacy Notice and
Print Name

Understand my rights contained in the notice.

By way of signature, I provide the office of Dr. Dale E. Rhodes, DDS with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's signature (or Guardian)

Date

Witness

Date