Cosmetic & Family Dentistry

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HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ("Authorization")

By signing this Authorization, you agree to the release of your Protected Health Information[1] as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA[2] Privacy Rule.[3] If you have questions about this Authorization, please contact the our office. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

Your contact information (please complete):

Patient name:	
Patient address:	
Patient email address: (Optional)	
Patient phone number:	

I authorize South Huron Dental named above to use or disclose and obtain Protected Health Information described herein: Information needed for the completion of my dental treatment including, but not limited to, dental x-rays, prescription history, oral health condition and dental treatment completed.

Such information may be released when deemed necessary by South Huron Dental to those South Huron Dental staff members involved in my treatment, staff members responsible for insurance

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1 "Protected Health Information" is information (i) about your physical or mental health or condition, health care, or the payment for the health care; (ii) that identifies you directly or indirectly *(i.e.*, there is a reasonable basis to believe that the information could be used to identify you); and (iii) that is maintained or transmitted by the Health Plan.

2 "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996.

3 The "Privacy Rule" refers to regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA.

claim filings, staff members tasked with treatment coordinating, contracted dental laboratories as needed, my insurance company as requested by my insurance, any policy holder and/or responsible party, and dental specialist solicited to aid in the completion of my treatment.

Personal information may be only released at the request of the patient or the legal representative of the patient. To obtain such information, the following is required: 1) Photo identification; 2) Signed authorization from Patient or legal representative; 3) If applicable, proper documentation of legal representation (i.e. proof of guardianship, power of attorney, executed health proxy, etc. If patient is deceased, a death certificate with a power of attorney or court order of personal representative).

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

Expiration of this Authorization:

This Authorization will automatically expire one year after the date that I sign it unless I (the patient) indicate an earlier date or event here: _____.

Your rights with respect to this Authorization:

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization.

If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to South Huron Dental to the address or email address indicated on the first page of this Authorization. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.

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.

_____ _____

Patient Signature Date

OR

_____

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other:_____