HIPPA AUTHORIZATON FORM

Authorization for Use or Disclosure of Protected Health Information

I _____ authorize Dr. Steven Rhodes D.D.S to use and disclose (release) the protected health information described below to:

[ ] **Information is not to be released to anyone.** (if so, skip the next steps and sign below)

OR

Name(s): **Relationship:**

_____ _____

_____ _____

_____ _____

Health Information to be disclosed (check all that apply):

[ ] My complete health record (including but not limited to diagnosis, lab tests, prognosis, treatment and billing for all conditions

OR

[ ] My complete health record, as described above, with the exception of the following information: (check as appropriate)

[ ] Mental Health Records [ ] Communicable Diseases (including HIV and AIDS)

[ ] Alcohol/drug abuse treatment [ ] Other (specify) _____

The health information may be used to enable the persons I authorize to know and understand my condition and my treatment options, for treatment or consultation, for claims payment purposes or related reasons.

Effective period: This authorization for release of information covers the period of care from (check one): [ ] All past, present, and future periods, **OR**

[ ] Date: _____ to _____

Extent of HIPPA Authorization:

This authorization shall be in force and effect until _____ at which time this authorization expires. I understand I have the right to revoke this authorization in writing at any time. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____ _____

Signature of Patient or Representative Date

_____

Printed name of Patient

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