Authorization Form for Use or Disclosure of Patient Information (HIPPA)

Patient Name: _____

Patient's Date of Birth: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPPA Privacy regulations.

Specific description of the patient information to be used or disclosed (Check box below):

☐ Any and all health information unless otherwise specified

☐ Health information as specified below:

_____

The following person(s) may receive this patient information (Name and Relationship):

_____

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at 4020 W. Goeller Blvd., Ste. A, Columbus, IN 47201. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Signature of Patient or Patient's Personal Representative:

_____ _____

(Signature) **(Date)**

If Personal Representative:

Print Name: _____

Signature: _____ Relationship to Patient: _____