Children's Dental Surgery

# HIPAA Authorization for Release of Health Information

Patient Name: _____ DOB (MM/DD/YY): _____

Home Address: _____ Phone: _____

**Purpose of Form:** This form is used to authorize the release of Protected Health Information (PHI) to certain individuals and/or entities. By submitting this form, I acknowledge that I understand and agree that:

- This authorization is voluntary and will expire one (1) year from the date I sign this authorization. I may revoke this authorization at any time but must do so in a writing submitted to the practice, and the revocation will not apply to information that has already been released.
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.
- I may not be denied treatment if I do not sign this form, except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating PHI for disclosure to a third party.
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations.

**Who May Receive and Disclose Your Information:** I authorize the disclosure of my individually identifiable health information to the following individual(s) and/or organization(s).

**The type(s) of information identified above may be disclosed** to the individual(s) and/or organization(s) identified below:

☐ At my request or the request of the individual or organization

☐ Only for the following purpose(s): _____
(No purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose)

| Name | Area Code + Phone # | Relationship to Patient | Type of Information | Comments |
|---|---|---|---|---|
| | | | ☐ All health information<br>☐ Other: See Comments | |
| | | | ☐ All health information<br>☐ Other: See Comments | |
| | | | ☐ All health information<br>☐ Other: See Comments | |
| | | | ☐ All health information<br>☐ Other: See Comments | |

**Acknowledgement:** I understand that:

- The named company may not be required to agree to the restriction(s) requested. Even if the restriction is denied, patients and their authorized representatives will generally have an opportunity to agree or object prior to disclosures to persons involved in patient care. If the named company agrees to a requested restriction, it will be binding except in the case of emergency treatment. If restricted information is released for emergency treatment, the named company will request the provider not to further use and/or disclose that information.
- I may make a request for confidential communications of my health information by alternative means or to an alternative location. However, I understand that such request is applicable only to information held by the named company and disclosure by alternative means may not be protected and could endanger me. I understand that requests for electronic communications (such as by fax and email) may be intercepted by others and the named company is not responsible if such intercepts occur.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient or Patient's Representative Relationship to Patient (if applicable)

***YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT***