

Contemporary Dentistry, PLLC

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HIPAAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I authorize Contemporary Dentistry to use and disclose the protected health information described below to (individual person seeking information, such as spouse, relative, or friend)

_____.

This authorization for release of information covers all past, present, and future periods of healthcare in this facility.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payments, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient: _____

Date: _____