Lady's Island Dental

HIPAA Release of Information
AUTHORIZATION FORM

I hereby authorize Lady's Island Dental and its affiliates, its employees and agents, to release to my current insurance carrier and/or my physician my personal health information maintained by Lady's Island Dental (e.g., information relating to the diagnosis, treatment, claims, payments and health care services provided to me and which identifies my name, address, social security number, Member ID) except any information about me that is not necessary, for the purpose of helping me to resolve claims and health benefit coverage issues and consult with my physician. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my or my representative's signature below and shall expire the date I cease being a patient-of-record of Lady's Island Dental. I understand that I have a right to revoke this authorization by providing written notice to Lady's Island Dental. However, this authorization may not be revoked if Lady's Island Dental, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization, should I request it. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Patient's Name: _____

Patient's Signature: _____ **Date:** _____

OR

Parent / Guardian Signature: _____ **Date:** _____

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____ *Date:* _____

Name of Witness: _____

Signature of Witness: _____ *Date:* _____

Dental Office Use Only

I tried to obtain written authorization by the individual noted above but was unable to obtain authorization because:

__ An emergency prevented us from obtaining authorization
__ A communication barrier prevented us from obtaining authorization
__ The individual was unwilling to sign
__ Other:_____

Staff Member signature:_____Date:_____