LADY'S ISLAND DENTAL

HIPAA Privacy Authorization Form
(HIPAA Release Form)

Patient Name: _____DOB: _____

[ ] I authorize the release/disclosure of any and all information including any and all contents of my dental record, including diagnosis, treatment, prognosis, financial, billing and insurance information. This information may be released to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] Information is not to be released to anyone.

The purpose of this request is for personal reasons. I understand that I have the right to revoke this Authorization, in writing, at any time by notifying the office above. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by this rule.

I understand that my health care provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that I will be financially responsible for any dental work provided by this office and will I be responsible for filing any claims with my dental insurance company.

This Authorization will expire at such time that:
[ ] I decide to revoke this Authorization in writing

Messages

Please call - **[ ]** my home **[ ]** my work **[ ]** my cell number:_____

If unable to reach me:
[ ] please leave a detailed message
[ ] _____

The best time to reach me is _____

I understand that this office will try to accommodate my wishes about my contact information, but may have to contact me at other numbers if unable to contact me at my requested number/location.

Signed:_____Date:_____