HIPAA Privacy Authorization Form

I understand that I have certain rights to privacy regarding my protected health information (PHI) afforded to me by the Health Insurance Portability and Accountability Act 1996 – HIPAA.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more detailed description of the uses and disclosures of my PHI and my rights under HIPAA.

There might be times when I am not available either physically or health-wise to discuss my PHI and the following designees are authorized to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

_____ _____

Name (PRINT) Relationship (Emergency Contact)

_____ _____

Name (PRINT) Relationship

Extent of Authorization: I authorize the discussion of the following dental record information:

☐ Dental Treatment ☐ Dental Images ☐ Health History ☐ Billing Information ☐ **Any and All**

☐ Other/specified dates/specified treatment (please explain): _____

This authorization shall be in force and effect for **one year** or until _____ (*date/event*), at which time this authorization expires.

I understand that I have the right to revoke this authorization in writing at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

I understand that I have the right to request restrictions on how my PHI is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions.

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

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.

☐ I authorize Dr. Moriarty/staff to leave messages at my ☐ home ☐ cell ☐ work telephone

☐ I authorize Dr. Moriarty/staff to send mailers to my mailing address (ie) reminder cards

☐ I authorize Dr. Moriarty/staff to send email to my email address: _____
or to use the following address: _____.

_____ _____ _____

Print Patient Name Patient/Guardian Signature Date

_____ _____ _____

Relationship if not patient **SIGN HERE TO REVOKE CONSENT** **DATE OF REVOCATION**