INDIVIDUAL PATIENT'S AUTHORIZATION

Privacy Practices Acknowledgement
I have received the Notice of Privacy Practices and I have
been provided an opportunity to review it.

Patient Name_____
(Please Print)
Signature_____
Birthdate_____
Date_____

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

1. **Individual Patient (or Personal Representative) Confirming** the **Authorization.**

I give my authorization to use or disclose my protected dental information as described in Section 2 Below. I give this authorization voluntarily.

Name_____
Street Address:_____
City_____ State_____
Telephone Number_____
Email Address_____
Patient Account Number_____

2. **The Use And/Or Disclosure Authorized**

Describe in detail the protected dental information you are authorizing to be used and/or disclosed.

_____
_____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use and/or to disclose the protected dental information described above.

_____
_____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and/or use your protected dental information.

_____
_____

Describe each purpose for which you are authorizing your protected health information to beused and/or disclosed.

_____
_____

3. **Ending This Authorization**

Select one of the following two choices.

☐ This authorization will end on the following date:_____

☐ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below:

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4. **Changing Your Mind About This Authorization**

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I *understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.* In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

5. **Signing This Authorization Is Not A Condition Of Treatment**

I understand that under most circumstances a dental care provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of m protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. **Possibility of Re-disclosure**

I understand that information disclosed under this authorization may be re-disclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient re-disclosed my health information.

7. **Individual Patient's Signature**

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form

Signature_____ ***Date***_____

If this authorization form is being signed by a personal representative for the individual patient:

Personal Representative's Name:_____

Signature:_____

Relationship To Patient:_____

You Have A Right To Have A Copy Of This Form After You Sign It. Submit the authorization to the Privacy Official and include a copy in the individual patient's dental record.