HIPAA (Health Insurance Portability & Accountability Act)

privacy act that was created in 1996 by Congress; its sole purpose is to protect individuals and their medical privacy.

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.

2. The use and/or disclosure authorization:

The protected dental information you are authorizing to be used**:** *Current & future treatment*

The people and/or organizations that you are authorizing to use and/or disclose the protected dental information described above**:** *Richard Hardt's Live Oak Dental*

The people and/or organizations that you are authorizing to receive and use your protected dental information**:** *Insurances, Dental Specialists, and Pharmacies*

Each purpose for which you are authorizing your protected information to be used and/or disclosed**:** *Billing your dental insurances, Referring out to a Dental Specialist, Calling in prescriptions, and Confirming dental appointments.*

3. 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 in your office. However, I understand that I may not revoke this authorization for any action taken before receipt of my written notice. In addition, I understand that if I end this authorization as a condition of obtaining insurance coverage, and if I revoke this authorization, the insurance company has the right to contest my claims under this insurance policy.

4. 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 use and/or disclosures of my protected information for research purposes may be a condition of my treatment if I am undergoing research related information. Under some circumstances, a health plan may condition enrollment in a health plan or my eligibility for benefits on my proving an authorization permitting the health plan to make enrollment and eligibility determinations.

5. Possibility of re-disclosure:

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

6. 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 personal and health information described in this form with the people and/or organizations named in this form.

Privacy Practices Acknowledgment: I have received the notice of Privacy Practices and I have been provided with an opportunity to review it.

_____ _____

Signature of Patient (or if a minor–Signature of Parent or Guardian) Date