HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)

Authorization

I authorize Nu-Smile Family Dentistry (healthcare provider) to use and disclose the protected health information described below to _____ (individual you allow seeking the information)..

Extent of Authorization

I authorize the release of my complete health/dental record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). This medical information may be used by the person I authorize to receive this information for medical treatment or consultation,billing or claims payment,or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. 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.

_____ Date: _____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient