

Patient's Authorization Form

This form is required by the Health Insurance Portability and Accountability Act of 1996 in compliance with the privacy regulation effective for this office on April 14, 2003, **only if our office wishes to use or disclose your protected health information for any other purpose not clearly spelled out in our office Privacy Policy Notice.**

To use or disclose your protected health information in such cases, our office must receive prior written authorization from you, the patient. Our office may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.

The purpose for which our office is requesting your authorization is as follows:

The information to be disclosed would be:

The information will be disclosed to the following entity:

Dates for which authorization would be valid:

From _____ to _____

By agreeing to this authorization, you understand that the potential for information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the privacy regulation of HIPAA. You also understand that you are entitled to receive a copy of this authorization form.

If you agree to these terms, sign below:

I, _____, give my authorization to Dr. Chivari and Dr. Hasten's Dental Office for the purpose stated above. I understand that I can revoke this authorization at any point in the future by submitting written notice to Dr. Chivari and Dr. Hasten's Dental Office.

Patient's signature: _____ Date: _____