

## HIPAA Authorization for Release of Protected Health Information

This sample HIPAA Authorization for Release of Protected Health Information ("Authorization") is being provided by Patterson as a courtesy to its customers and is not legal advice nor intended to be relied on as legal advice. Your dental practice should consult with its legal counsel about the HIPAA Privacy Rule and HIPAA authorization requirements prior to using this sample Authorization.

This sample Authorization is intended to comply only with the federal HIPAA Privacy Rule requirements. Dental practices are required to comply with state laws and rules that are more stringent than the HIPAA Privacy Rule and this Authorization should be revised to reflect any applicable state law requirements that are more stringent than HIPAA. This sample Authorization may also need to be revised to reflect the privacy policies and procedures of your dental practice. Your dental practice should consult with its legal counsel to revise this sample Authorization.

**David K. Walton, DDS, MS, PC**

### HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ("Authorization")

By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this Authorization, please contact the Privacy Official for the Dental Practice, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

#### **Our Dental Practice contact information:**

Dental Practice Name:	David K. Walton, DDS, MS, PC
Privacy Official for Dental Practice:	David K. Walton, DDS, MS
Dental Practice mailing address:	4026 S. Timberline Road Suite 120 Fort Collins, CO 80525
Dental Practice email address:	waltonimplants@gmail.com
Dental Practice phone number:	(970) 482-2210

#### **Your contact information (please complete):**

Patient name:	
Patient mailing address:	

Patient email address: (Optional)	
Patient phone number:	

**Protected Health Information that I am authorizing the Dental Practice to release (please check the records to which this Authorization applies):**

I authorize the Dental Practice named above to release the following Protected Health Information:

- Dental report(s)
- Dental image(s)
- All dental records relating to (specify injury or illness): \_\_\_\_\_  
\_\_\_\_\_
- All dental records received or created by the Dental Practice between the following dates:  
\_\_\_\_\_
- Other (specify) \_\_\_\_\_

**The reason for the release of the Protected Health Information (please check the reason(s) that apply):**

- Patient Request
- Review Patient's current care
- Treatment/ continued care
- Payment for care, including insurance
- Legal
- Obtaining Social Security Disability or other public benefits
- Other(specify): \_\_\_\_\_

**I am requesting that the Dental Practice release my Protected Health Information to (please complete):**

Organization name:	
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Person name or title:	
Mailing address	
Phone number:	

If you want your Protected Health Information to be provided to the organization/person by email, please provide the email address: \_\_\_\_\_.

If you want your Protected Health Information to be provided to the organization/person by fax, please provide the fax number: \_\_\_\_\_.

When your Protected Health Information is released as provided in this Authorization, the recipient may not have a legal obligation to protect its confidentiality and may redisclose it.

**Expiration of this Authorization:**

This Authorization will automatically expire one year after the date that I sign it unless I (the patient) indicate an earlier date or event here: \_\_\_\_\_.

**Your rights with respect to this Authorization:**

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization.

If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to the Dental Practice to the address or email address indicated on the first page of this Authorization. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

OR

\_\_\_\_\_  
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

- Parent     Guardian     Power of Attorney     Other: \_\_\_\_\_