BAILEY FAMILY DENTAL & BRACES

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:	Bailey Family Dental & Braces
Privacy Official for dental practice:	Office Manager
Dental Practice mailing address:	308 Dartmouth Drive Midland, MI 48640
Dental Practice phone number:	(989) 631-6075

Your contact information (please complete):

Patient Name:	
Patient mailing address:	
Patient e-mail address (optional):	
Patient phone number:	

I authorize the Dental Practice to disclose the following protected health information about me to the entity, person, or persons identified below:

_____Entire patient record (reasonable fee charged) OR check only those items of the record to be disclosed:
_____Dental image(s)
_____All dental records relating to (specify):_____

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

_____Patient Request
_____Other: (please specify): _____

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

Organization Name:	
Person name or title:	
Mailing address:	

Phone 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 re-disclose 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 at the address or e-mail 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 Date

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

___Parent ___Guardian ___Power of Attorney

Other:_____