east cobb ORTHODONTICS

SMILES BY CAPPS & IACULLI

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ DOB: _____

Name of parent or guardian (if different than patient): _____

1. I hereby authorize all health care providers to use and/or disclose the protected health information ("PHI") described below to me or as directed below. The purpose of this request is for personal reasons.

2. I hereby authorize the release of PHI, defined here as the patient's complete dental record, including treatment, prognosis, financial, billing, and insurance information. I understand that my personal billing, financial and insurance information may be disclosed to those in paragraph 3 in order to be able to process claims with the insurance company and/or for personal reasons.

3. In addition to the authorization for release of my PHI described in paragraph 3 of this Authorization, I authorize disclosure of information regarding my/my child's billing, condition, treatment and prognosis to the following individual(s) (please include caregivers that may accompany children to appointments):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

4. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until I am no longer a patient at this practice, or until such time as I render payment for my own treatment, or _____, (date or event) at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

7. I understand that my health care provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that payment will be collected at the time services are provided and I will be responsible for filing any claims with my dental insurance company.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number: _____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____
The best time to reach me is (day) _____ between (time) _____

_____ _____

Signature of Patient Date