



HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____

Patient's Name: _____

Date of Birth: _____

I. DISCLOSURE I authorize Slate Dental to disclose my dental records to the individuals listed below:

1. **Name:** _____

Relationship: _____

2. **Name:** _____

Relationship: _____

3. **Name:** _____

Relationship: _____

II. TERMINATION This authorization will terminate (please check one):

- Upon sending a written revocation to Slate Dental.
- On the following date: _____
- Other: _____

III. ACKNOWLEDGMENT OF RIGHTS I understand and acknowledge the following rights regarding this authorization:

- I have the right to revoke this authorization in writing at any time, except where uses or disclosures have already been made based upon my original permission.
- I understand that I might not be able to revoke this authorization if its purpose was to obtain insurance.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back.
- I understand that it is possible that medical records and information used or disclosed with my permission may be re-disclosed by a recipient and may no longer be protected by the HIPAA Privacy Standards.



- I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create medical records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
- I will receive a copy of this authorization after I have signed it.
- A copy of this authorization is as valid as the original.

IV. SIGNATURE

Signature of Patient: _____

Date: _____

(IF THE PATIENT IS UNABLE TO SIGN, PLEASE COMPLETE THE SECTION BELOW)

The patient is unable to sign due to (please check one):

- Being a Minor. Patient is _____ years old and considered a minor under state law.
- Being Incapacitated. Patient is incapacitated due to:
_____.
- Other: _____

Signature of Representative: _____

Date: _____

Print Name: _____

Relationship to Patient:

- Parent
- Spouse
- Guardian
- Other: _____