DENTAL HEALTH CENTER

EAU CLAIRE • CADOTT • CHIPPEWA FALLS • STANLEY • THORP

HIPAA AUTHORIZATION

for use or disclosure of Protected Health Information (PHI)

I authorize Dental Health Center to use and disclose my protected health information as described below.

Extent of Authorization:

(Regarding where to call/leave message) **I authorize Dental Health Center to (mark all that apply)**

- ☐ Leave a detailed message on my cell phone including appointment or treatment information
- ☐ Leave a message on my cell phone, but no details

  Cell phone number that is authorized_____
- ☐ Leave a detailed message on my home answering machine including appointment or treatment information
- ☐ Leave a message on my home answering machine, but no details
- ☐ Leave a detailed message on my work voice mail including appointment or treatment information

  Home number that is authorized_____

(Regarding who we can speak with to leave a message) **I authorize Dental Health Center to leave a message with (mark all that apply)**

- ☐ My spouse/significant other _____ Detailed Y / N
- ☐ Roommate _____Detailed Y / N
- ☐ Employer Detailed Y / N or ☐ Co-worker Detailed Y / N

  Work number that is authorized_____
- ☐ Child(ren)_____Detailed Y / N

(Regarding anyone else you authorize us to speak with about your information) **Please mark all that apply:**

I authorize Dental Health Center to discuss detailed ☐ billing/account information ☐ treatment information ☐ or any aspect of my medical history with the following people

- ☐ My spouse/significant other _____
- ☐ Parents (College Students)_____
- ☐ Health Care Giver/facility_____
- ☐ Other_____

  (example: Power of Attorney, Guardian or family member)

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I authorize Dental Health Center to mail me post card reminders to my home address on file with general appointment information (date and time) ☐

For CHILDREN: Please complete if someone other than a parent is bringing your child to an appointment.

I authorize Dental Health Center to discuss detailed ☐ billing/account information or ☐ treatment information or post-operative instructions with the following people:

- ☐ Grandparent(s) _____
- ☐ Sibling _____
- ☐ Other (babysitter/nanny)_____

CONCLUSION AND SIGNATURE FOR ALL PATIENTS:

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Effective Period:

This authorization for release of information covers the period of healthcare from

a. ☐ _____ to _____ (specific time frame i.e. 1 year)

b. ☐ all past, present, and future periods unless changed in writing.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient or Legal Guardian Signature Date

_____

Patient's Printed Name