HIPAA Authorization for Release of Protected Health Information

Patient Name: _____

I hereby authorize the use and disclosure of individually identifiable dental health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Information to be used or disclosed:

Radiographs____ Treatment Plan____ Finances____ Medical Information____

I authorize the following person(s) to make the requested use or disclosure of the above health information:

Name: _____ Name: _____

Messages:

I authorize Benchmark dental to leave voicemail messages YES NO (circle one)

Internet Communication:

I grant my permission for the dental practice to upload and store confidential patient information such as account, appointment and clinical information to the internet. I understand that the Benchmark Dental is not liable for any harm related to the theft of my personal information.

Patient Signature:_____

Date:_____

** I understand I may revoke or change this authorization at any time by notifying Benchmark Dental in writing.

Documents: Hipaa signature page