HIPAA Authorization Form for Woodland Family Dentistry

Patient Name:_____

Billing Address:_____

Home Telephone:_____Cell:_____Work:_____

Emergency Contact:_____ Relationship:_____

Telephone for Emergency Contact:_____

☐ **I have received or refused a copy of this office's posted Notice of Privacy Practices.**

☐ **I agree that the dental practice may communicate with me electronically at the email address below.**

Email Address (PLEASE PRINT CLEARLY):

_____@_____

☐ **I would like the dental practice to communicate with me other than at my primary phone number and/or address.**

Patient Name (print):_____

Alternative Communication Request (Please tell us the way you would like us to communicate with you, and/or the address you would like us to use):

_____

_____

☐ **Payment Information**

Your request may affect our normal billing and payment procedure. Please specify your alternative method for handling payment.

_____

_____

TURN FORM OVER TO COMPLETE AUTHORIZATION

☐ **Authorization to use or disclose patient information**

I hereby authorize the use and disclosure of the patient information 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. Specific description of the patient information to be used or disclosed:

☐ **Financial**

The following person(s) may receive this patient information:

_____

_____

☐ **Protected Health Information**

The following person(s) may receive this patient information:

_____

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official, Dr. Jennifer F. McFinton at 510 N. Ann Arbor St., Saline, MI 48176. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

☐ **For Personal Representatives of the Patient**

Print Name of Personal Representative:_____

Relationship to the Patient:_____

Signature of Patient or Patient's Personal Representative:

_____Date_____

For office use only: Copy of signed authorization provided to the individual:

Date:_____

Initials:_____