HIPAA NOTICE OF PRIVACY PRACTICES &

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the office of my dentist to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms:

1. What may be released: Completed, existing, and proposed dental treatment, Dental x-ray information, Medical history, Treatment referral information, Insurance authorization and benefit breakdown, Account information, such as balances due, amounts paid, and insurance coverage
2. To whom may the information be released: Professional associates, partners and referring doctors, third party billing entities and insurance carriers

   Additional Persons or Entities:

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3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual): To enable dental services to be provided
4. Expiration date or event relating to the individual or purpose for the release: Term shall end upon termination of professional-patient relationship.
5. Restrictions on disclosure of my PHI as follows:

   ____

   ____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

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Patient Name

I HAVE HAD THE OPPORTUNITY TO REVIEW THE PRIVACY PRACTICES IN PLACE AT MCKEE DENTAL.

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Patient or Guardian/representative Signature Date

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

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Patient or Guardian/representative Signature Date