MOUNTAIN SHADOWS FAMILY DENTAL

HIPAA Privacy Authorization Form

Authorization for USE OR DISCLOSURE of protected Health Information (REQUIRED by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)** I Authorize Dr. Matthew J. Garrett DDS dba Mountain Shadows Family Dental to use and disclose the protected health information described below to the following individuals seeking the information:

_____ _____

Name of Authorized Party **(Other then Patient)** Relationship to patient

_____ _____

Name of Authorized Party **(Other then Patient)** Relationship to patient

_____ _____

Name of Authorized Party **(Other then Patient)** Relationship to patient

This authorization for release of information covers the period of healthcare from **(CHECK ONE)**:

☐ _____ to _____. **OR** ☐ All Past, Present, and Future periods.

Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ I authorize the release of my complete health record with the EXCEPTION of the following information:

- ☐ Mental health records
- ☐ Communicable disease (Including HIV and AIDS)
- ☐ Alcohol/Drug abuse treatment
- ☐ Other (Please Specify): _____

- This medical information maybe used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- This authorization shall be inforce and effect **UNTIL** _____(Date or Event), at which time this authorization expires.
- 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.
- I understand that my treatmeant, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sigh 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.

_____ _____

Signature of Patient/Guardian **Date**

Patient's Printed Name: _____