

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. Jacob Allen DDS** to use the protected health information described below to

_____.
[patient name]

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or insurance claims payment, or other purposes as I may direct.

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 treatment will not be conditioned on whether I sign this authorization.

I understand the 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 or personal representative

Printed name of patient or personal representative

Relationship to patient if patient is a minor

Date