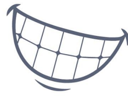
ANDREW WHEATLEY, DDS
AT TECUMSEH RIDGE DENTAL



AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. **Patient's name**:

Last name: ____________________ First name: ____________________ Middle: ____________________

2. **Date of Birth**: ____/___/___

3. **SSN**: ____-____-_____

4. **Information to be Used or Disclosed**:

My dental information relating to my entire dental record.

5. Purpose of Use or Disclosure:

Treatment, Payment or Health Care Operations or to the Following Family Members:___________________

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature of the Patient or Guardian of Minor: ______________________________

Date of signature: ____/____/______

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("***HIPAA***").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: to the extent information has already been shared based on this authorization. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.