Masterpiece 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)

186 South 1100 East · American Fork, Utah 84003 · Phone:(801)756-5136

I authorize **Masterpiece Dental** to use and disclose the protected health information described below

to_____ (Any parent, spouse, or other person we have permission to discuss your account, billing, or treatment with).

Duration of Authorization

All past, present, and future periods, until I personally request an end to the communication through a written form of request to terminate all communication with the above person listed.

Extent of Authorization

☐ I authorize the release of my complete health and dental records including billing, payments, and dental insurance information.

OR

☐ I DO NOT authorize the release of my health and dental records.

_____

This information may be used by the person I authorize to receive this information for dental treatment or consultation, billing or 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, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign 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.

Patient (printed full name)_____ Date _____

Signature of patient _____
OR
Signature of Personal representative, guardian, or parent responsible for patient_____