ELMORA DENTAL ASSOCIATES

PATIENT DISCLOSURE HIPAA AUTHORIZATION FORM

Date: _____

Patient Name: _____

I authorize Elmora Dental Associates to disclose the patient's protected health information (PHI) only in the specific manner, for the named reason, and to the specific individuals listed below.

I authorize Elmora Dental Associates to send films and/or reports containing the patient's PHI consisting of name, date of birth, case number, date and nature of any clinical history to any other physicians and healthcare providers that request this information to perform treatment and/or consultation regarding the patient's dental health.

I authorize Elmora Dental Associates to send reports containing the patient's PHI consisting of name, date of birth, social security number, address, insurance information, date of and description of any clinical history to their billing department and agencies connected with the billing department to carry out request for payment for treatment.

Elmora Dental Associates will continue to send post card reminders; leave voice mail and messages to confirm, change or notify you of your appointment, unless specifically requested otherwise by patient.

In addition to the above-mentioned parties, Elmora Dental Associates has my permission to release my records and PHI to:

1.) _____

2.) _____

I understand and acknowledge Elmora Dental Associates's notice of privacy practices. At any time, a full detailed copy of the HIPPA privacy act is available to me if I so choose to have one.

A full and updated copy of HIPAA Consent of Services is displayed at the office reception desk and I have been provided the opportunity to review it. I abide by all the disclosures and policies specified therein. If I should have any questions and/or concerns about this matter, I will address my concerns to the office management.

_____ _____

Name & Relation to Patient: (Self/Parent/Guardian) Date

_____ _____

Signature: (Patient/Parent/Guardian) Date