HIPAA - Release of Information Authorization Form

CANNON FAMILY DENTISTRY

Patient Information

Patient First Name | MI | Patient Last Name | Patient Date of Birth

HIPAA - Release of Information Authorization Form

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), must first be authorized. Authorization includes the signature of the individual authorizing the release of their information. Information will not be available to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the childs consent.

I want to provide the authorization ☐ Y ☐ N

INFORMATION REGARDING PERSON AUTHORIZING RELEASING HIS/HER INFORMATION

Name of Person Authorizing Release | Date of Birth Person Authorizing Release

PERSONAL INFORMATION TO BE RELEASED

☐ Dental and/or medical services claim information

☐ Prescription, diagnostic, treatment, and/or care management service

THE ABOVE INFORMATION MAY BE RELEASED AND/OR RECEIVED BY

☐ Email ☐ Phone ☐ Fax ☐ Mail

The following is an authorization allowing _____ to release information to whomever you designate. _____ is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that the office may release my information to

Relation of person/organization that the office may release information to

Phone number of person/organization that the office may release information to

Consent

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practices Notice of Privacy Practices.

Patient's Signature | Date | Doctor's Signature | Date