DENTAL HEALTH CENTERS

EAU CLAIRE • CADOTT • CHIPPEWA FALLS • STANLEY • THORP

HIPAA AUTHORIZATION

for use or disclosure of Protected Health Information (PHI)

I authorize Dental Health Center to use and disclose my protected health information as described below.

Extent of Authorization: I authorize Dental Health Center to (you can check more than one)

☐ Leave a message with appointment and treatment information

Cell phone number that is authorized_____

Home number that is authorized_____

Work number that is authorized_____

☐ Email appointment reminder _____

☐ Text message appointment reminder_____

DHC may also leave a message with:

☐ My spouse/significant other _____ Detailed Y / N

☐ Roommate _____Detailed Y / N

☐ Employer Detailed Y / N or ☐ Co-worker Detailed Y / N

☐ Child(ren)_____Detailed Y / N

I authorize Dental Health Center to discuss detailed ☐ billing/account information ☐ treatment information or any aspect of my ☐ medical history with the following people

☐ My spouse/significant other _____

☐ Parents (College Students)_____

☐ Health Care Giver/facility_____

☐ Other_____

(example: Power of Attorney, Guardian or family member)

☐ I authorize Dental Health Center to mail me post card reminders to my home address on file with general appointment information (date and time).

For CHILDREN/MINORS: Please complete if someone other than a parent is bringing or picking up your child.

I authorize Dental Health Center to discuss detailed ☐ billing/account information or ☐ treatment information with the following people

☐ Grandparent(s) _____

☐ Sibling _____

☐ Other (babysitter/nanny)_____

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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.

FOR ALL PATIENTS:

Effective Period:

This authorization for release of information covers the period of healthcare from

a. ☐ _____ to _____

b. ☐ all past, present, and future periods.

_____ _____

Patient or Legal Guardian Signature Date