PHYE
FAMILY DENTISTRY

HIPAA AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Last Name: _____ First: _____ MI: _____ Birthdate: _____

Section I

I authorize Phye Famliy Dentistry, PA and its representatives to use or disclose the following health/dental information in Section II as it relates to my care.

Phye Famliy Dentistry, PA may disclose the above information to the following person or persons:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I understand that the person(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section II

I give my permission to disclose my complete health/dental record but not limited to, diagnoses, test results, treatment and billing and insurance information for all conditions.

Section III

This authorization to share the above listed information is valid (choose one box below):

❑ a) From _____ to _____.

OR

❑ b) All past, present and future periods.

OR

❑ c) The date of the signature in Section IV until the following event:

_____

Section IV

I understand that I am permitted to revoke this authorization to share my health/dental data at any time and can do so by submitting a request in writing to:

Phye Famliy Dentistry, PA
401 S. Clairborne, Suite A
Olathe, Kansas 66062

Patient (or Parent/Guardian) Signature: _____ Date: _____

Print Name: _____