AUTHORIZATION FORM TO DISCLOSE PATIENT PHI

HIPAA laws prevent this office from disclosing most patient Protected Health Information (PHI) without written authorization. This office is allowed to discuss patient PHI with the actual patient, a minor patient's parent, a minor patient's legal guardian, and another approved treatment provider. Please declare who else can receive patient PHI.

Patient Name: _____

Patient's Date of Birth: _____

Choose one of the following:

☐ I authorize Murrieta Dental Care to allow patient Protected Health Information (PHI), as described by HIPAA, to be shared (as necessary) to following person/people:

For example: to a spouse, partner, grandparent, grown child, caretaker, or personal representative

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

☐ Share the patient Protected Health Information (PHI) with no one beyond the HIPAA laws.

Restrictions:

Description of the patient information to be allowed:

- ☐ Anything
- ☐ Specifically: _____

Purpose(s) of this use or disclosure:

- ☐ Any Reason
- ☐ Specifically: _____

Acknowledgement:

I approve the above access/control to patient Protected Health Information (PHI). This permission shall remain in effect until a signed and dated revocation is received in writing at Murrieta Dental Care.

Signature of Patient, Minor Patient's Parent, or Minor Patient's Legal Guardian:

_____ Date_____

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