GRIFFITTS FACIAL & ORAL SURGERY

HIPAA[1] AUTHORIZATION FORM

Patient Name: _____ **Date of Birth**: _____

Address: _____ **Phone #:** _____

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Patient or guardian authorizes and directs any physician, other health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau or other health care clearinghouse and covered entities[2] that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services (collectively, the "Providers"), to release and disclose the Protected Health Information[3] described herein to the following party(ies) as my agent, to be treated as I would with respect to my rights regarding the use and disclosure of my protected health information.

Please list those individuals whom you give your permission to speak to Griffitts Facial & Oral Surgery in your behalf. **If the individual is not listed below, our office will not be able to communicate with them regarding your treatment or billing in our office.**

Name _____ Relationship _____ Phone #_____

Address _____

Name _____ Relationship _____ Phone #_____

Address _____

Name _____ Relationship _____ Phone #_____

Address _____

A. Limitations on Authorization

Extent of Authorization

I authorize the release of **all** of my protected health information, including: history/physical exam results, progress notes, physician's orders, patient allergies, consultation reports, discharge summaries, pathology reports, operative reports, emergency room record, laboratory reports, x-rays, imaging reports, abstracts or summaries and the contents of medical records.

Period of Health Care Covered by the Authorization

This authorization of the release of my protected information covers all past, present and future protected health information.

Electronic Disclosure

I further acknowledge that any protected health information disclosed pursuant to this authorization may be re-disclosed electronically and consent to the protected health information being disclosed electronically.

[1] The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") establishes standards and procedures that covered entities must follow when disclosing a patient's protected health information.
[2] Covered entities are defined by HIPAA as health plans, health care clearinghouses and health care providers who conduct certain financial and administrative transactions electronically. These entities are bound by the privacy standards of HIPAA even if they contract with others to perform some of their essential functions.
[3] Under HIPAA, protected health information is individually identifiable information that is created, collected, or transmitted by a HIPAA-covered entity in relation to payment for healthcare services. Protected health information includes, but is not limited to, diagnoses, treatment information, medical test results, prescription information, birth dates, gender, ethnicity, contact and emergency contact information.

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Patient's Name _____ Today's Date _____

B. Effective Time Period

This authorization will be in effect until I expressly revoke authorization.

C. Patient Rights and Acknowledgments

i) This release does not affect my ability to obtain treatment, payment, or eligibility for benefits.

ii) I recognize that I have the right to inspect or copy the protected information held by covered entities.

iii) I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent a provider has acted in reliance on it.

iv) 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.

I understand that I can request and obtain a copy of the HIPAA Privacy Notice at any time. The date this form is signed is the effective date of this authorization.

_____ _____

Signature of patient, parent, or guardian Date

_____

Printed name of patient, parent, or guardian: Relationship