HIPAA Privacy Authorization Form for the Office of Robert D. Perrott, DMD

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act)

I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (‘‘PHI’’) described below

Authorization for release of PHI covering the period of health care all past, present and future periods.

I hereby authorize the release of PHI my complete health and dental health record.

In addition to the authorization for release of my PHI, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s): Name

Name _____ Relationship _____

Name _____ Relationship _____

This medical/ dental information may be used by the persons I authorize to receive this information for medical / dental treatment or consultation, billing or claims payment, or other purposes as I may direct. This authorization shall be in force and effect until nine (9) months after my death at which time this authorization expires.

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.

_____ Date: _____

Signature of Patient