HIPPA Authorization Form

For family members/guardians

I, Sample Patient or Sample Patient Self, on 06/26/2024, hereby authorize the use or disclosure of my protected health information as described below:

1. Authorized persons to use and disclose protected health information: :

Sample Patient Spouse

2. Description of information to be disclosed/discussed: :

Medical history,Dental history,Dental treatment plan (future recommended work),Insurance information,Payment Information,Make dental treatment decisions,ALL PAST, PRESENT, AND FUTURE PERIODS OF HEALTHCARE INFORMATION MAY BE SHARED

3. Validity of Authorization Form:

This Authorization form is valid beginning TODAY, 06/26/2024, and expires exactly one year (365 days) from this date.

4. ACKNOWLEDGEMENT:

I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action *already taken* in relation on this authorization cannot be reversed, and my revocation will not affect those past actions.

Signature of Patient

Patient, Sample

Signed on 06/26/2024 11:08:23 AM