Patient Consent & Authorization for Release of Protected Health Information- HIPAA

Patient Name:_____ Date of Birth:_____

Address:_____

City, State, ZIP Code:_____

Patient Authorization

I hereby authorize ***Southeast Texas Dental Center*** to release, use, or disclose of my health information to: _____Relation to Patient:_____ Contact Info:_____

I understand that, per my request, this authorization will permit the above named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 *(HIPAA).*

I understand that I may revoke this authorization at any time by providing written notification.

I understand that this authorization will expire one year from this signed date.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized discloser.

Patient or Personal Representative

Signature: _____ Date:____/____/____

Name: _____

Relationship to Patient: _____

For Office Use Only

Received By: _____