HIPAA Privacy Authorization Form

Authorization for Use of Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

_____**I.** I authorize Dr. Connor and staff to perform all procedures that are discussed and mutually agreed to in the course of treatment upon myself/the patient. I authorize Dr Connor and staff to transfer my records to another healthcare provider in the event of a referral for treatment. This authorization in no way obligates me to continue a doctor/patient relationship with any healthcare provider except by and of my own choosing.

_____**II.** I authorize Dr. Connor to release to hospital or health care service plans, insurance companies, self-insured, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me that is needed to review, investigate or evaluate any claim for benefits. If my coverage is under a group master agreement held by my employer, an association, trust fund, union, or similar entity, their authorization also permits disclosure to them for purposes of utilization review or financial audit.

_____**III.** I authorize Dr. Connor to submit claims for payment for services to my dental insurance company/companies, on my behalf and in my name and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. If the benefits are paid in full at the time of service, benefits will be assigned to me. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

_____**IV.** I have read a copy of this office's Notice of Privacy Practices. I know that I have the right to receive a copy of this authorization. I understand that I have the right to revoke this authorization, in writing, at any time.

_____**V. I authorize this office to make routine calls to confirm my appointment and understand a message may be left with a responsible person or an answering machine. I further agree that Dr. Connor and/or staff members may communicate with me in email and text messages when necessary. This includes but not limited to: text/email to confirm appointments, questions regarding potential treatment, questions following active treatment.**

I prefer that I be contacted on my:

Home number ◯ **Cell number** ◯ **Work number** ◯ **Other:** _____

_____**VI. PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION**: (this includes spouse, children, parents, and any care takers who can have access to this patient's records):
Name: _____ Relationship: _____
Name: _____ Relationship: _____

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative