AUTHORIZATIONS

SOUTHWEST DENTISTRY

HIPPA RELEASE OF HEALTH INFORMATION

The Health Insurance Portability and Accountability Act (HIPAA) is a law implementing national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. This form allows the disclosure and authorization of your personal health information to be released to whom you specify. This may include X-Rays, treatment plans, financial records, and other information pertaining to your records with Southwest Dentistry. Information disclosed to specified individuals may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

To whom may the information be released - Full name & relationship of recipients:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

Expiration date or event relating to the individual or purpose for the release: _____

You may revoke authorizations at any time by written or electronic note explaining the changes in the authorization. Please send them to our business addresses or email info@sw-dentistry.com. The only exception to your right to revoke authorization is if we have already acted in reliance upon the authorization. Signing this form is voluntary and indicates you have read and understand the HIPAA law and authorize the disclosure of personal health information to specified parties in this form.

Printed Patient Name: _____

Patient, Parent/Guardian Signature: _____

Date: _____