HIPAA AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards

Print Patient Name: _____ Date of Birth:_____

My Authorization

I authorize the following using or disclosing party: Burba Dental Partners

To use or disclose the following health information: (please check all that apply)

_____ All of my health information

_____My health information relating to the following treatment/ condition:

_____

_____ Other:

_____

_____

The above party (Burba Dental Partners) may disclose this information to the following recipient:

Name of person or title of the organization: _____

Address:_____

City, State, Zip: _____

Phone:_____

Fax:_____

Email:_____

The purpose of this authorization is (please check all that apply):

_____At my request

_____Other:

_____

_____

Does this authorization have an end date?:

_____No

_____Yes: End Date: _____

Signature of Patient: _____ Today's Date: _____