HIPAA AUTHORIZATION FORM

PATIENTS NAME: _____

- I have been offered and/or received a copy of the currently effective Notice of Privacy Practices for Precision Dental.
- I understand that I may request a copy of the privacy policies at any time.
- I understand that my PHI (Protected Health Information) can and will be used for purposed of treatment and for payment from both myself and/or third party.
- I may refuse to sign
- EXPIRATION: 3 years from initial signature, patient reaches age of 18.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

_____ _____

*Please **print** your name* *Please **sign** your name*

☐ Patient ☐ Parent ☐ Guardian ☐ Other: _____