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**Board Certified Pediatric Dentist**

### **HIPAA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT**

*Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (S 164.508(a))*

I \_\_\_\_\_ (patient name or legal guardian) understand that as part of my/ my child's healthcare, this facility originates and maintains health records describing my/ my child's health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my/or my children's care and treatment
- a means of communication among the health professionals who may contribute to my/my child's healthcare
- a source of information for applying my diagnosis and surgical information to my/my child's bill
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information, uses, and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

### **PRIVACY RULE OF PATIENT CONSENT AGREEMENT**

*Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (S164.506(a))*

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent
- This facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment or healthcare operations and that this facility is not required by law to agree to the restrictions requested
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Patient(s) Name (if a minor): \_\_\_\_\_

Patient / Guardian Printed Name: \_\_\_\_\_

Patient / Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_