Patrick C. Creevan, D.D.S., Inc.

Pediatric Dentistry

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Authorization Form for Release of Protected Health Information

Patient Name:_____**Patient's Date of Birth:**____/____/_____

I hereby authorize the use and disclosure of individually identifiable dental health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific Description of Information to Be Used or Disclosed:

_____
_____

Purpose for Disclosure:

_____
_____

I authorize **Patrick C. Creevan, D.D.S.** to make the requested use or disclosure of the above health information.

Person(s) Receiving My Authorized Information Include:

_____
_____

I understand that I may revoke this authorization at any time by notifying Patrick C. Creevan, D.D.S, Pediatric Dentistry, in writing. If I choose to do so, my revocation will not affect any actions taken by Patrick C. Creevan, D.D.S., Pediatric Dentistry, before receiving my revocation. I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This Authorization Expires On: _____/_____/_____

Signature of Patient or Patient's Personal Representative:

_____Date_____

If Personal Representative:

Print Name_____Relationship to Patient_____

NOTE: This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "Authorization" for the use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.

CAUTION: If you intend to use the requested information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum necessary to accomplish the intended purpose of the request. To be valid, an authorization must be clearly separate from other language on a page and executed by a signature which serves no purpose other than to execute the authorization. It can either be handwritten by the person who signs it or in typeface no smaller than 8 point (this is 8 point).
For office use only: Copy of signed authorization provided to the individual: Date:_____ Initials_____.