Des Moines Family Dentistry

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HIPAA Acknowledgement

Authorization to Release Protected Health Information

I understand that I am 18 years of age or older and that my dental records and information are protected under the Health Insurance Portability and Accountability Act (HIPAA).

I hereby authorize Des Moines Family Dentistry to release and discuss my protected health information, including but not limited to dental records, treatment plans, x-rays, billing, and insurance information.

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

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☐ * **By checking this box, I understand this authorization will remain in effect until the I revoke authorization in writing.**

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

I understand that I may revoke this authorization at any time by submitting a written request to the dental office, except to the extent that action has already been taken.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that I may inspect or copy the protected health information described by this authorization.

Name of person filling out this form: *

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_____

Relationship to patient: *

☐ Self ☐ Parent ☐ Step-parent ☐ Grandparent ☐ Legal Guardian ☐ Other

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Response Date: _____