OLM ORTHODONTICS
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Specialist in Orthodontics

HIPAA Authorization Form - Use or Disclosure of Patient Health Information (PHI)

This authorization form allows you to choose whether we may use or share your health information for purposes not otherwise permitted by law. We may have indirect treatment relationships with you, (such as laboratories that only interact with the Doctor and not patients), and we may have to disclose personal health information for purposes of treatment, payment, dental insurance, or health care operations. You may refuse consent to use or disclose Personal Health Information (PHI) but must do so in writing. You do not have to sign this form to receive treatment or benefits.

Patient Name: _____

Patient's Date of Birth:_____

☐ I authorize Olm Orthodontics to use or disclose my personal health information 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.

Example of information to be shared:	Example of purpose for use or disclosure:
Dental records	Coordination of care
X-rays and imaging	Insurance or billing
Treatment information	Legal or administrative purposes
Billing and insurance information	

☐ I understand that by listing the following persons involved in care, you consent to the release of your Personal Health Information to those individuals involved in your care or payment for that care. Please list the person(s) below:

_____ _____

_____ _____

_____ _____

☐ I understand that I may revoke this authorization at any time by following the directions in the Notice of Privacy Practices. I understand that my revocation must be in writing.

Expiration. This authorization expires when the following event occurs or on the following date. If no event or date selected, the default will be one year from the date signed.

- ☐ One year from the date signed
- ☐ Event occurs: _____
- ☐ Specific Date: _____

☐ **I received a copy of this authorization (paper or electronic).**

Signature of Patient: _____ Date: _____
(OR *Patient's Personal Representative)*

Personal Representative's Name:_____

Signature: _____ Relationship to Patient:_____