Hidden Lakes Dental Care, PC

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING AUTHORIZATION

Name: ____

Social Security Number: ______________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Authorization: By signing this form, you will authorize our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. This includes, but is not limited to, combining of all family members PHI on billing statement. If you are not covered by anyone else's insurance and you wish to have a separate billing account from family members, you may request such in writing.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Authorization. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Authorization. We encourage you to read it carefully and completely before signing this Authorization.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Practice Administrator, Hidden Lakes Dental Care, PC**

Telephone: **630-759-0077** Fax: **630-759-0082**

Address: **680 W. Boughton Rd., Bolingbrook, IL 60440**

Right to Revoke: You will have the right to revoke this Authorization at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Authorization will *not* affect any action we took in reliance on this Authorization before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Authorization.

SIGNATURE

I, ____________________________________, have had full opportunity to read and consider the contents of this Authorization form and your Notice of Privacy Practices. I understand that, by signing this Authorization form, I am giving my Authorization to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations as described in the Notice of Privacy Policies and this Authorization form.

Signature: ____ Date: ________________________

If this Authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
Include completed Authorization in the patient's chart.

REVOCATION OF AUTHORIZATION

I revoke my Authorization for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Authorization will *not* affect any action you took in reliance on my Authorization before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Authorization.

Signature: ______________________________ Date: ______________________