HIPAA RIGHT OF ACCESS AUTHORIZATION

Patient Name: _____ Date of Birth: _____

Date of Authorization: _____

Health Information to be disclosed upon the request of the person (s) named below: (check one)

- ◯ Disclose my complete dental record including but not limited to diagnoses, lab tests, prognosis, treatment, and billing for all conditions.
- ◯ Disclose my dental information relating to the following treatment or condition: _____
- ◯ Disclose my dental record for the following dates: _____
- ◯ Disclose my dental record, as above, but do not disclose the following (check as appropriate):
  - o My health information related to drug and/or alcohol abuse
  - o My health information related to HIV/AIDS
  - o My health information related to _____
- ◯ Other information to be used of disclosed: (describe information in detail) _____

  _____

Person(s) Authorized to Receive the Disclosure:

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

This Authorization will: (check one)

- ◯ Not expire
- ◯ Expire on ____/____/_____
- ◯ Upon the happening of the following event: _____

Authorization and Signature:

I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature: _____ Date: _____