HIPAA Authorization for Use or Disclosure or Health Information

Our Notice of Privacy Practices provides information about how William G Harper DDS PC may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name (print): _____

Date of Birth: _____

I. My Authorization

a. I authorize **William G Harper DDS PC** to use or disclose the following health information: (check the appropriate box).

- ☐ All my health information
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information covering the period of healthcare from _____ (Start Date) to _____ (End Date).
- ☐ Other: _____

b. The above party may disclose this health information to the following recipient(s):

1. Name: _____
   Phone: _____ Email: _____
2. Name: _____
   Phone: _____ Email: _____
3. Name: _____
   Phone: _____ Email: _____

☐ I do not authorize any person(s) to discuss or receive information pertaining to my account.

c. This authorization ends:

- ☐ On (Date): _____
- ☐ When I am no longer a patient of the practice
- ☐ When the following event occurs: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send to the disclosing party listed below:

William G. Harper DDS PC
235 Wythe Creek Road
Poquoson, VA 23662

I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that is it possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I may request a copy of this authorization at any time after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ **Date:** _____

If the patient is a minor or unable to sign, please complete the following:

- ☐ Patient is a minor: _____ years of age
- ☐ Patient is unable to sign because: _____

Authorized Representative Signature: _____ Date: _____

Print Name of Representative: _____

Authority of representative to sign on behalf of the patient:

- ☐ Parent
- ☐ Legal Guardian
- ☐ Court Order
- ☐ Other

III. Notice of Privacy of Practices

The signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for the authorized party listed above and have read and understood its content.

Signature of Patient or Authorized Representative: _____

Date: _____

You May Refuse to Sign This Acknowledgment

For Office Use Only

We attempted to obtain a written acknowledgment of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because (Team Member: Indicate reason, date, print your name, and sign your name):

- ☐ Individual refused to sign (Date of refusal): _____
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ Other: _____

Team Member Signature: _____ **Date**: _____