HIPAA Release of Information Authorization Form

This form provides authorization for the use or disclosure of your protected health information as required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164. Please complete as indicated below, and sign and date at the bottom. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

1) **AUTHORIZATION:** I authorize **Naples Family Dentist** to use and disclose the protected health information described below to _____ (individual seeking the information).

2) **EFFECTIVE PERIOD:** This authorization for release of information covers the period of healthcare from:

   a) _____ to _____

   OR

   b) all past, present, and future periods.

3) EXTENT OF AUTHORIZATION:

   a) I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

   OR

   b) I authorize the release of my complete health record with the exception of the following information:

   ❑ Mental health records ❑ Communicable diseases (including HIV and AIDS)

   ❑ Alcohol/drug abuse treatment ❑ Other (please specify): _____

   c) I authorize messages regarding the below approved items left at the following phone number(s):

   _____

   ❑ Billing Information ❑ Appointment Calls ❑ Test Results ❑ Other:_____

4) **PURPOSE:** This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5) **EXPIRATION:** This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6) **REVOCATION:** I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7) **TREATMENT:** I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8) **PROTECTION:** I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Patient Signature Date:

First:_____Last:_____

Printed name of patient or personal representative or Legal Guardian and his or her relationship to Patient