Sinking Spring
Family Dental, LLC

HIPAA AUTHORIZATION FORM

Disclaimer: This document is provided solely for reference purposes. Covered Entities under HIPAA are advised to refer to their Institution's Privacy Policy for specific requirements for the HIPAA Authorization.

I, _____, give permission to Sinking Spring Family Dental to:

_ disclose the following protected health information to:

_____

_____

_____

[Name(s) of entity to receive information]

Information to be disclosed (check all that apply):

_ Dental Records

_ Dental Treatment Plan

_ Other: _____

_____

_____

This authorization expires _____

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization.

Finally, you may revoke this authorization in writing at any time by sending written notification to Sinking Spring Family Dental at 803 Mountain Home Road Sinking Spring, PA 19608. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Printed Name of Patient or Personal Representative

_____

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