HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ("Authorization")

By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this Authorization, please contact the Privacy Official for the Dental Practice, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

Our Dental Practice contact information:

Dental Practice Name:	**South Shore Pediatric Dentistry, LLC**
Privacy Official for Dental Practice:	Darren Butler
Dental Practice mailing address:	5 Federal Street **Weymouth, MA 02188**
Dental Practice email address:	info@sskidsdentistry.com
Dental Practice phone number:	781-340-5437 (KIDS)

Your contact information (please complete):

Patient name:	
Patient mailing address:	
Patient email address: (Optional)	
Patient phone number:	

Protected Health Information that I am authorizing the Dental Practice to release (please check the records to which this Authorization applies):

I authorize the Dental Practice named above to release the following Protected Health Information:

__x_ Dental report(s)

_x__ Dental image(s)

__x_ All dental records relating to (specify injury or illness):_____
_____

___x All dental records received or created by the Dental Practice between the following dates:

_____

___ Other (specify) _____

The reason for the release of the Protected Health Information (please check the reason(s) that apply):

__x_ Patient Request

_x__ Review Patient's current care

_x__ Treatment/ continued care

__x_ Payment for care, including insurance

_x__ Legal

__x_ Obtaining Social Security Disability or other public benefits

___
Other(specify):_____

I am requesting that the Dental Practice release my Protected Health Information to (please complete):

Organization name:	
Person name or title:	
Mailing address:	
Phone number:	

If you want your Protected Health Information to be provided to the organization/person by email, please provide the email address:_____.

If you want your Protected Health Information to be provided to the organization/person by fax, please provide the fax number: _____.

When your Protected Health Information is released as provided in this Authorization, the recipient may not have a legal obligation to protect its confidentiality and may redisclose it.

Expiration of this Authorization:

This Authorization will automatically expire one year after the date that I sign it unless I (the

patient) indicate an earlier date or event here: _____.

Your rights with respect to this Authorization:

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization.

If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to the Dental Practice to the address or email address indicated on the first page of this Authorization. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other:_____