Patient Authorization to Use and Disclose Protected Health Information

Patient Name:	If Minor Patient, Parent/Guardian Name:
Patient Address:	**Patient Phone:**
Patient Date of Birth:	**Date of Request:**

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our HIPPA Notice of Privacy Practices without your prior authorization.

I hereby authorize Gregory Palmer, D.M.D. Family & Cosmetic Dentistry and any of its employees to use and/or disclose my Patient Protected Health Information to the following person(s), entity(s), or business associate(s) of this practice via the below email:

_____

_____

I understand that if the person(s), entity(s), or business associate(s) of this practice receiving this information authorized by my below signature are not health care providers or a health plan covered by federal privacy regulations, the information may be re-disclosed to additional parties and no longer protected by these regulations for reasons beyond our control.

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent on the uses and/or disclosures pursuant to this authorization or if the authorization was obtained as a condition of obtaining insurance coverage verification.
- Information used and/or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA Privacy Rules.
- This practice will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my providing authorization for the requested use and/or disclosure.
- I have the right to access my Protected Health Information to be used and/or disclosed.
- I will receive a copy of this completed and signed authorization form upon my request.

_____ _____

Patient, Parent/Guardian Signature Signature Date

_____

Printed Name and Relationship to Patient