HIPPA Consent Form for Use or Disclosure of Patient Health Information (PHI) – Dr. Stephen M. Lee & Dr. Diana C. Fong

Instructions: *Please complete. You may request a copy of this completed form. For questions, ask to speak with the dental practice's privacy officer.*

I, [patient's name or representative]_____authorize use or disclosure of my protected health information to third party entities for the purpose of

1. For treatment
2. To obtain payment for treatment
3. For healthcare operations or as required by law enforcement

I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be canceled or modified at any time upon provision of a written notice to this dental practice. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I understand I may have a copy of this authorization.

The health information to be used or disclosed is limited to the following:
[ ] X-rays, photographs, dental history, medical history for insurance claims and specialist referrals. *(you may note dates, procedures or use other description here)*

_____

_____

Signature: _____

Print name:_____

Date Signed: _____This authorization is valid until _____or 3yrs

Signed by: ☐ Patient ☐ Parent/legal guardian if under 18 years old

☐ Personal representative of the patient — *describe the legal authority that permits the representation:*_____