DENTAL ARTS GROUP
1136 Hartford Avenue • Johnston, RI 02919

HIPPA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act -45 CFR Parts 160 and 164

1. I hereby authorize **Dental Arts Group** to use and/or disclose the protected health information described below to _____.

2. This Authorization for Release of Information covers the period of health care from _____ to _____ OR ☐ all past, present and future periods:

a. **I hereby authorize the release of my complete medical and dental record with the exception of:**

☐ Mental health record
☐ Communicable diseases (including HIV and AIDS
☐ Alcohol/drug abuse treatment
☐ Other: (please specify _____

3. This medical and dental information may be used by the person I authorize to receive this information for treatment or consultation, billing or claims payment, or other purposes I may direct.

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

5. I understand 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.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. 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.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient