HIPAA AUTHORIZATION FORM

Patient's Full Name	Patient's Social Security Number/Medical Record Number
Address	Patient's Date of Birth
City, State Zip Code	Patient's Telephone Number

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

John A. Dusenbury, Jr., DMD
EZ Dental / 912-925-9190
11139 Abercorn St., Suite 8
Savannah, GA 31420-0582

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (please specify) _____

Signature: _____ Date: _____

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize my health care provider **John Dusenbury DMD** to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient #1: I authorize my health care information to be released to the following recipient(s):
Name: _____
Relationship: _____
Address: _____

- ❑ Full disclosure
- ❑ Partial disclosure (specify) _____

Recipient #2: I authorize my health care information to be released to the following recipient(s):
Name: _____
Relationship: _____
Address: _____

- ❑ Full disclosure
- ❑ Partial disclosure (specify) _____

Term: I understand that this Authorization will remain in effect:

- ❑ From the date of this Authorization until the _____ day of _____, 20___.
- ❑ Until I revoke this Authorization in writing.

Re-disclosure: I understand that my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the continuation or quality of my treatment at EZ Dental. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to EZ Dental at the address listed on reverse side of this form. The revocation will be effective immediately upon my health care provider's receipt of my written notice.

Questions: I may contact EZ Dental for answers to my questions about the privacy of my health information at 912-925-9190.

_____	_____	_____
Signature	Date	Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Name of Guardian/Representative	Relationship	Date	Witness