

HIPPA Privacy Rule Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.508(a))

I _____ understand that as part of my healthcare, Dental Studio of Pasadena Originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who may contribute to my health care.
- A source of information for applying diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy and understand the Notice of Information Practices that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my protected health information to another covered entity. I have the right to review Dental studio Of Pasadena notice prior to signing this authorization. I authorize the disclosure of my protected information as specified below for the purpose and to the parties designated by me.

PHI Authorized: _____

Purpose Authorized: _____

Parties to whom my PHI is authorized to be released: _____

I understand that:

- I have the right to request restrictions as to how my health information may be used and disclosed to carry out treatment, payment r health care operations by other covered entities.
- I may revoke the consent in writing at any time, except to the extent that Dental Studio of Pasadena has already taken action in reliance thereon. I understand that this action may limit my future treatment options.

_____ Accepted _____ Denied

Signature of patient or Legal Representative Witness _____

Printed Name of Patient or Legal representative Witness _____

Date: _____