AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Carolina Dental Care
Dr. Tara Howell
8620 Crown Crescent Court
704-814-6006

1. INDIVIDUAL PATIENT

I give my authorization to use or disclose my protected health information as described in section 2 below.

Your name:_________________________ Social Security Number________________________

Legal Responsibility

___If you are 18 years old or older, you are legally responsible for yourself, check here

___If you are under age 18 and with a parent or legal guardian today, check here

___If you are an emancipated child or teenager and your parents no longer have custody over you, check here

___If you are a child or teenager and your parents are divorced, please check here. Below please list the name of the parent or guardian who has custody over you_________________________________

2. THE USE AND/OR DISCLOSURE

A. I understand that under the HIPAA regulations, my health information will be used and disclosed to any health care provider who is involved with my medical treatment or services, my health insurance plan and any medical billing clearinghouse who is involved with your insurance claims fulfillment.

B. Under these new regulations the following people must be authorized by you to have access to your health information: your spouse, other family members and friends; nurse or home aid; legal guardian; or other person/organization who is not involved with your medical treatment, insurance plan, or payment.

Below please list the people/organizations that you authorize to have access to your information:
Persons/Organizations Receiving the Information:

1) Name_________________________________ Contact Phone:____________________________
Address:_______________________________ Relationship to the Patient:__________________
What Specific Information to Disclose____
What Date Will the Disclosure Expire____

2) Name_________________________________ Contact Phone:____________________________
Address:_______________________________ Relationship to the Patient:__________________
What Specific Information to Disclose____
What Date Will the Disclosure Expire____

3. CHANGING YOUR MIND ABOUT THE AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to your Privacy Officer.

4. METHOD OF CONTACT

I authorize the office of Carolina Dental Care to contact me the following manner:

___Home telephone____________________
___OK to leave message with detailed information
___Leave message with a call back number only
___OK to fax to this number______________
___Work telephone number_______________
___OK to leave message with detailed information
___Leave message with a call back number only

___ Written Mail
___OK to mail to my home address
___OK to mail to my work/office address

5. STATEMENT OF UNDERSTANDING

I have reviewed and I understand this authorization. I also understand that my health information will be used or disclosed to certain business associates of Carolina Dental Care who are part if the health care process. These business associates will also keep your health information confidential.

By:____ Date:_____________________
(Patient)
Or By:______________________________________ Date:____________________
(Patient's Representative)
Description of representative's Authority____