



WINTERHOLLER DENTISTRY
IMPLANTS | COSMETIC | TMJ | ORTHODONTICS

**HIPAA Release of Information
AUTHORIZATION FORM**

I, _____ hereby authorize Payson Dental Care and its affiliates, its employees and agents, to release to *my current insurance carrier and/or my physician* my personal health information maintained by Payson Dental Care (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me:

_____ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]** for the purpose of helping me to resolve claims and health benefit coverage issues *and consult with my physician*. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the date I cease being a patient-of-record of Payson Dental Care. I understand that I have a right to revoke this authorization by providing written notice to _____. However, this authorization may not be revoked if _____, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Patient's Name: _____

Patient Signature: _____

Date: _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____