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HIPAA Privacy Authorization Form

*** Authorization for Use or Disclosure of Protected Health Information*

I authorize Dentistry for Children to use and disclose the protected health information for **Patient Name:**_____. This authorization for release of information covers all present and future periods that above named family members are associated with this practice.

I authorize the release of my child(ren) complete health record(s) to be used for medical or dental treatment, consultation, billing or claims payment purposes. I may pay for a service in full and request that Dentistry for Children not submit the protected health information as it pertains to a particular health situation to my dental insurance.

In the event of a breach of the patient's information, Dentistry For Children will make every attempt to notify the legal guardian and explain how it will be corrected.

I give Dentistry for Children permission to E-mail the health information for the patient listed above to the necessary parties as described in this authorization.
I understand that referrals by Dentistry for Children are not based on any special treatment or expectation by the referral source, and that Dentistry for Children refers my child(ren) solely based on need and best professional available for the dental or medical situation.
I understand that my treatment or eligibility for benefits will not be conditional on whether I sign this Authorization. Any 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.

Printed Name of Parent or Guardian	**Date**
Signature of the Parent or Guardian	**Relationship to Patient**

Privacy Officer for Dentistry For Children
Linda Beaubien
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