ROCHESTER DENTAL
4893 Rochester Road
Suite C
Troy, MI 48085

HIPPA AUTHORIZATION FOR USE AND DISCLOSURE

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996

AUTHORIZATION TO RELEASE PRIVATE HEALTHCARE INFORMATION

By law, we are **only authorized** to speak directly with the patient regarding any form of private healthcare information which includes scheduled appointments, test results, medication, your office visit and surgery

Please check one of the below:

_____I **give** Rochester Dental authorization to speak with my immediate family, or persons which I specify below, regarding my private healthcare information:

_____

_____I **do not authorize** Rochester Dental to speak with anyone regarding my private healthcare information

_____ _____
Patient or personal representative signature Date

BY SIGNING THIS FORM, YOU PERMIT THE HEALTHCARE PROVIDERS TO DISCLOSE YOUR CONFIDENTAL PERSONAL HEALTH INFORMATION

Copy of Patient Privacy Notice is available in the office

For Office Use Only

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

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement