DENTAL IMPLANT CENTER OF ROYAL OAK

HIPAA AUTHORIZATION FORM

Patient Name: _____ Date: _____

May we share your Protected Health Information with a family member or other? Yes ☐ No ☐ If yes: _____
(Names)

May we leave messages on your **HOME** Voice Mail Yes ☐ No ☐ Phone #: _____
May we leave message on your **MOBILE** Voice Mail Yes ☐ No ☐ Phone #: _____

Please DO NOT LEAVE ANY messages on any of my Voice Mails ☐

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Dental Implant Center of Royal Oak** to use/or disclose certain protected health and/or financial information about me to any doctor or health care facility that they refer me to with my consent and understanding OR to _____

This authorization permits **Dental Implant Center of Royal Oak** to use and/or disclose the following individually identifiable health information about me, including but not necessarily limited to: handwritten, digital notes ad chartings, diagnosis, radiographs, photographs, lab, prescriptions, therapeutic, treatment records. The information will be used or disclosed for the following purposes: To assist other healthcare providers/entities in providing your health care OR for insurance billing and receiving payments on your behalf. (If disclosure is requested by the patient, purpose may be listed as "at the request of the individual."). Included in this section is any entity that you have authorized to receive your medical records. In such cases, ALL your chart data will be provided unless the request explicitly requests only specific information.

I HAVE BEEN OFFERED A PRINTED COPY OF THE FULL HIPAA LAW AND UNDERSTAND THAT I MAY REVOKE THIS SIGNED DOCUMENT AT ANYTIME BY CONTACTING THIS DENTAL OFFICE.

☐ I **DO** consent to send and receive *text messages that do not use encryption services* to and from this dental office and to have my insurance claims sent on my behalf. All email communication IS SENT using an encryption service. X_____ (Initial)

☐ I **DO NOT** consent to receive email communication and/or text message that do not use encryption services. I understand that all communication and documents must be picked up in person or sent via certified mail via scanned documents on a CD disc at my personal expense. All electronic insurance claims will be my sole responsibility. X_____ (Initial)

☐ I **DO** give advance permission to **Dental Implant Center of Royal Oak** to release my dental radiographs and/or records *to my personal email address only* if I ever request this in the future. I understand this request may be made over the phone for my convenience but will **ONLY** be sent to the email address that I write today. I acknowledge it may take ten business days to process my request. X_____ (Initial) Email address: _____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire upon your written request to resend this authorization.

The practice receives payment or other numeration from a third party in exchange for using or disclosing the PHI if you have billed dental insurance and we bill on your behalf.

I do not have to sign this authorization to receive treatment from **Dental Implant Center of Royal Oak**. I understand that if I refuse to sign this form Woodward Dental Group cannot bill my insurance on my behalf and that I will be responsible to pay for all services in advance. I also have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it might be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 4251 Coolidge Hwy., Royal Oak, MI 48073, (248) 547-3700.

I HAVE BEEN OFFERED A COPY OF THIS NOTICE AT THE TIME OF THIS SIGNING

Signature of Patient/Legal Guardian: _____ Date: _____