Gove FAMILY DENTISTRY

HIPAA AUTHORIZATION FORM

Patient's Full Name | **Patient's Date of Birth**

Address | **Patient's Telephone Number**

City, State Zip Code

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose personal information about me:
   Gove Family Dentistry
2. The following person (or class of persons) may receive disclosure of protected health information about me: **OR** None ☐

   check if address is the same as the patient's ☐

   His/her/its Name

   Address

   City, State Zip Code

   check if address is the same as the patient's ☐

   His/her/its Name

   Address

   City, State Zip Code
3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying Gove Family Dentistry in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. This authorization expires on _____, 201___. **OR** This authorization does not expire ☐

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Signature of Individual
(The person about whom the information relates)

Date of Individual's Signature

OR, if applicable –

Signature of Guardian or Personal Representative of Patient's Estate

Date of Guardian's/Personal Representative's Signature

Description of Authority to Act for the Individual