Name DOB Date

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.508(a))

I understand that as part of my healthcare, Golden Heart Dental originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

-a basis for planning my care and treatment
-a means of communication among the health professionals, medical and dental, who may contribute to my health care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify the services billed were actually provided
- a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

By signing this form, I am stating that I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I authorize the disclosure of my Protected Health Information as specified above for the purposes and to the parties designated by me.

Signature Printed Name Date