

### **Authorization to Release Protected Health Information**

*(insert name of patient or patient's personal representative) authorizes (insert name of your office) to release (insert specific description of relevant records) to (insert name of employer through which benefit plan is offered and appropriate department, such as "human resources") for purposes of informing (insert name of employer) of issues pertaining to benefits provided through (insert name of plan).*

This authorization shall expire *(insert date or triggering event, such as upon patient's departure from practice).*

I understand that I have the right to revoke this authorization, and that I must do so in writing. I understand that any such revocation will not affect any actions taken by *(insert name of your office)* in reliance on this authorization before its revocation.

I understand that *(insert name of your office)* may not refuse to treat *(insert name of patient)* if I refuse to sign this authorization.

I understand that *(insert name of employer or department receiving protected health information under this authorization)* may be able to redisclose protected health information provided by *(insert name of your office)*, and that the protected health information will no longer be covered by the federal privacy regulations implementing the Health Insurance Portability and Accountability Act of 1996.

*(Signature-If this authorization is signed by the patient's personal representative, describe the personal representative's authority to act on behalf of the patient)*

**NOTE:** When filled out completely, this form should meet the requirements for an authorization under the HIPAA privacy regulations. However, your state's law may have additional consent requirements for the release of patient information, and this form may not meet those requirements. To determine whether there are additional consent requirements in your state, please contact your state dental association or your personal attorney.