Pinckney
Family Dentistry

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HIPAA Release of information
AUTHORIZATION FORM

I, _____ hereby authorize ***Pinckney Family Dentistry***, to release to _____ **[Insert full name of person/organization]** my personal health information maintained by ***PinckneyFamily Dentistry, information*** relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to ***Pinckney Family Dentistry.*** However, this authorization may not be revoked if ***Pinckney Family Dentistry,*** employees or agents have acted on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization form.

I further understand that this authorization form is voluntary and that I may refuse to sign this authorization form. My refusal to sign will not affect my eligibility for benefits or payment for or coverage of services.

Name: _____

Signature: _____

Date: _____