

Mowry Dental Group  
**HIPAA AUTHORIZATION FOR RELEASE OF  
PROTECTED HEALTH INFORMATION  
("Authorization")**

**Last Updated April 1, 2011**

By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this Authorization, please contact the Privacy Official for the Dental Practice, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

**Our Dental Practice contact information:**

Dental Practice Name:	<b>Mowry Dental Group</b>
Privacy Official for Dental Practice:	<b>Sharon Fragoso</b>
Dental Practice mailing address:	<b>556 Mowry Ave #203 Fremont, CA 94536</b>
Dental Practice email address:	<b>rrsdental@gmail.com</b>
Dental Practice phone number:	<b>510 796 1636</b>

**Your contact information (please complete):**

Patient name:	
Patient mailing address:	
Patient email address: (Optional)	
Patient phone number:	

**Protected Health Information that I am authorizing the Dental Practice to release (please check the records to which this Authorization applies):**

I authorize the Dental Practice named above to release the following Protected Health Information:

\_\_\_ Dental report(s)

\_\_\_ Dental image(s)

\_\_\_ All dental records relating to (specify injury or illness): \_\_\_\_\_

\_\_\_ All dental records received or created by the Dental Practice between the following dates:

\_\_\_\_\_  
\_\_\_ Other (specify) \_\_\_\_\_

**The reason for the release of the Protected Health Information (please check the reason(s) that apply):**

- \_\_\_ Patient Request  
\_\_\_ Review Patient's current care  
\_\_\_ Treatment/ continued care  
\_\_\_ Payment for care, including insurance  
\_\_\_ Legal  
\_\_\_ Obtaining Social Security Disability or other public benefits

\_\_\_  
Other(specify): \_\_\_\_\_

**I am requesting that the Dental Practice release my Protected Health Information to (please complete):**

Organization name:	
Person name or title:	
Mailing address:	
Phone number:	

If you want your Protected Health Information to be provided to the organization/person by email, please provide the email address: \_\_\_\_\_.

If you want your Protected Health Information to be provided to the organization/person by fax, please provide the fax number: \_\_\_\_\_.

When your Protected Health Information is released as provided in this Authorization, the recipient may not have a legal obligation to protect its confidentiality and may disclose it.

**Expiration of this Authorization:**

This Authorization will automatically expire one year after the date that I sign it unless I (the patient) indicate an earlier date or event here: \_\_\_\_\_.

**Your rights with respect to this Authorization:**

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization.

If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to the Dental Practice to the address or email address indicated on the first page of this Authorization. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

OR

\_\_\_\_\_  
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

Parent       Guardian       Power of Attorney     

Other: \_\_\_\_\_