WILLIAM D. STEWART
FAMILY DENTISTRY

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
("Authorization")

By signing this Authorization, you agree to the release of your Protected Health Information[1] as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA[2] Privacy Rule[3]. 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	**William D. Stewart, D.M.D., P.A.**
Privacy Official for Dental Practice:	**Patti Stewart**
Dental Practice Mailing Address:	**1327 Drayton Road** **Spartanburg SC 29307**
Dental Practice Email Address:	**info@drbillstewart.com**
Dental Practice Phone Number:	**(864) 583-0793**

Patient Information

First Name _____ Initial _____ Last Name _____ Email: _____

_____ Phone: _____

City _____ State _____ Zip _____

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

- ☐ Dental Report(s)
- ☐ Dental Image(s)
- ☐ Other (specify) _____
- ☐ All dental records relating to (specific injury or illness): _____
- ☐ All dental records received or created by the Dental Practice between the following date: _____

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: (specific) _____

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

Organization name: _____ Person name or title: _____ Phone: _____

_____ If you want your Protected Health Information to be provided to the organization/person by email, please provide the email address (or fax): Email: _____

City _____ State _____ Zip _____ Fax: _____

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 redisclose 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 _____

1 "Protected Health Information" is information (i) about your physical or mental health or condition, health care, or the payment for the health care; (ii) that identifies you directly or indirectly (*i.e.*, there is a reasonable basis to believe that the information could be used to identify you); and (iii) that is maintained or transmitted by the Health Plan.

2 "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996.

3 The "Privacy Rule" refers to regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA.

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