HIPPA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

I hereby give my consent for Champagne Smiles to use and disclose my protected health information described to the following individual(s).

1. _____

2. _____

3. _____

I have the right to review the Notice of Privacy Practice prior to signing this consent. Champagne Smiles reserves the right to revise its Notice of Privacy Practices at any time. I am aware that by signing this form that I am authorizing my Personal Health Information to be released at any time to the authorized individual or individuals regarding my complete Mental Health records, Communicable diseases(including HIV/AIDS),Alcohol/drug abuse treatment, Dental records (x-rays, images, appointments, financials etc.) This includes all past, present and future information with no specific time period.

I am aware that unless written to Champagne Smiles to withhold my personal information that it will stay in effect and released to the individual(s) on file.

Signature of patient or personal representative:

_____

Printed name of patient or personal representative and his/her relationship to patient:

_____

Date: _____