HIPAA Privacy Authorization Form

Authorization for Use of Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

I. I hereby authorize Alan A. Dalessandro, DDS and such assistants to perform all procedures that are discussed and mutually agreed to in the course of periodontal therapy upon myself/the patient.

I authorize Alan A. Dalessandro, DDS as the current periodontist of record to transfer my records to another healthcare provider in the event of a referral for treatment. This authorization in no way obligates me to continue a doctor/patient relationship with any healthcare provider except by and of my own choosing. In the event I should choose to change periodontists, copies of my records will be provided to me and this consent will be no longer valid.

I agree for this office to make routine calls to confirm my appointment and understand a message may be left with a responsible person or an answering machine. I authorize the disclosure of my protected health information to not only another healthcare provider, but **also to the following individuals (i.e. family members, personal assistant, etc)**:

Name	Relationship to Patient	Phone Number

II. I authorize Alan A. Dalessandro, DDS to release to hospital or health care service plans, insurance companies, self-insured, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me that is needed to review, investigate or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union, or similar entity, their authorization also permits disclosure to them for purposes of utilization review or financial audit.

III. I authorize Alan A. Dalessandro, DDS to submit claims for payment for services to my dental insurance company/companies, on my behalf and in my name and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. If the benefits are paid in full at the time of service, benefits will be assigned to me. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

IV. I have received a copy of this office's Notice of Privacy Practices. I know that I have the right to receive a copy of this authorization if required. I understand that I have the right to revoke this authorization, in writing, at any time.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Print Name of Patient or Personal Representative | Relationship to Patient