HIPAA AUTHORIZATION FORM

Patient's Full Name | **Patient's Date of Birth**

Address | **Patient's Telephone Number**

City, State Zip Code

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose personal information about me:
   Gove Family Dentistry
2. The following person (or class of persons) may receive disclosure of protected health information about me: **OR** None ☐

   check if address is the same as the patient's ☐
   Name
   Address
   City, State Zip Code

   check if address is the same as the patient's ☐
   Name
   Address
   City, State Zip Code

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying Gove Family Dentistry in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Signature of Individual
(The person about whom the information relates)

Date of Individual's Signature

OR, if applicable –

Signature of Guardian or Personal Representative of Patient's Estate

Date of Guardian's/Personal Representative's Signature

Description of Authority to Act for the Individual