Patient Privacy Authorization Form

Starling Orthodontics, PLLC in compliance with **HIPAA** regulations requests the following information from or for ____.

(**PRINT PATIENT'S NAME**)

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below:

Description of disclosed information:

- Receiving recall cards for verification of appointments
- Displaying my name on the sign in sheet
- Receiving a message via recorder, voice mail or text message to confirm appointments
- Receiving a statement via mail or email for collection purposes
- Receiving emails regarding appointments and account issues

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by **HIPAA.**
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment.)

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA),** I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its policy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Privacy of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient or
Responsible Party Signature ____ Date __________________.

Relationship to Patient ____