AUTHORIZATION TO DISCLOSE HEALTH AND OTHER INFORMATION

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Midwest Dental's Notice of Privacy Practices, updated effective April 12, 2019. We are permitted to review our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Authorization of PHI Disclosure

I authorize Midwest Dental to disclose my health and other information about me and the treatment I am receiving from Midwest Dental, including protected health information ("PHI"), to the following recipients:

- Name of Person #1:_____Relationship to You: _____

  Purpose for Disclosure:
  This disclosure is at the request of the individual, unless another purpose is indicated here
  _____

- Name of Person #2:_____Relationship to You: _____

  Purpose for Disclosure:
  This disclosure is at the request of the individual, unless another purpose is indicated here
  _____

I understand that Midwest Dental will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form.

Revocation of Authorization

I understand that I may revoke this authorization at any time by sending a written request for revocation to Midwest Dental's Privacy Officer or by completing a new *Authorization to Disclose Health and Other Information* form. I understand that I may not revoke this authorization with respect to disclosures that my dental healthcare provider may have already made in reliance on this authorization. If I revoke this authorization, my dental healthcare provider will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when my dental healthcare provider discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. I understand that this authorization will expire 5 years from the date of signature below, unless I revoke it in writing or indicate another expiration date here: _____.

I understand and agree to the terms of this authorization.

Patient Name: _

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient: _____

Signature:_____ Date:_

To be completed by office personnel if form is not signed:

I,_____, attempted to obtain the patient's acknowledgement of receipt of Notice of Privacy Practices, but was unable to do so.

Reason acknowledgement and consent not obtained: _____

Employee Signature:_____ Date:_

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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By signing below, you are acknowledging that you have received a copy of Midwest Dental's Notice of Privacy Practices.

Patient Name: _

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient: _____

Signature:_____ Date: