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HIPAA RELEASE OF INFORMATION AUTHORIZATION FORM

| DOB:

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), **must first be authorized**. Authorization includes the signature of the individual authorizing the release of their information. Information **will not be available** to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year-old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the child's consent.

I want to provide authorization (Yes or No): _____

Name of person authorizing release (Patient's name): _____

Name(s) of persons authorized to access information other than authorizer (If no one, fill in with "N/A"):

_____

Personal Information to be released:

Check all that apply:

- ☐ **Dental and/ or medical services claim information**
- ☐ **Prescription, diagnostic, treatment and/ or care management services**
- ☐ **Records required by HHS or HIPPA- compliant health care operations**
- ☐ **Other:** _____

The following is an authorization allowing Katrina A. Thatch, DDS, PLLC to release information to whomever you designate. Katrina A. Thatch, DDS, PLLC is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s)

AUTHORIZATION CONSENT

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Patient's signature: _____ **Date:** _____